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ABSTRACT

This book describes the process of developing comprehensive health education programs in rural areas. Six school districts in the Pacific Northwest teamed up with specialists from five universities, an educational service district, and a regional educational laboratory to develop the curricula. The book includes an introduction, a summary, and eight chapters. Chapter 1, "Exploring the Myths," explains that poor health and poverty affect rural, as well as urban, children. Chapter 2, "Another Voice," summarizes the Children's Defense Fund report on rural children. Chapter 3, "Reaching Out to Communities," highlights the focus of the health education programs in the various school districts. Chapter 4, "Miseries Large and Small," advocates a comprehensive health education program involving topics such as drugs, alcohol, and AIDS as well as nutrition and personal hygiene. Chapter 5, "Time, Resources, and the 'M' Word," discusses school support, money and other resources, and program effectiveness. Chapter 6, "A Field Guide," presents an action plan for developing a comprehensive health education program. Chapter 7, "Building Bridges, Seeking Support" discusses assistance from higher education and other outside agencies. Chapter 8, "What We Learned," updates the current status of the health education programs. The appendix contains two charts describing health education scope and sequence, a health education assessment tool, an outline of curriculum categories, a description of the people involved in the project and book, references and additional reading, a technical summary, and sources for more information. (KS)

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We Can't Teach That Here – Or Can We?

RURAL COMPREHENSIVE HEALTH EDUCATION: FIELD EXPERIENCES AND GUIDE

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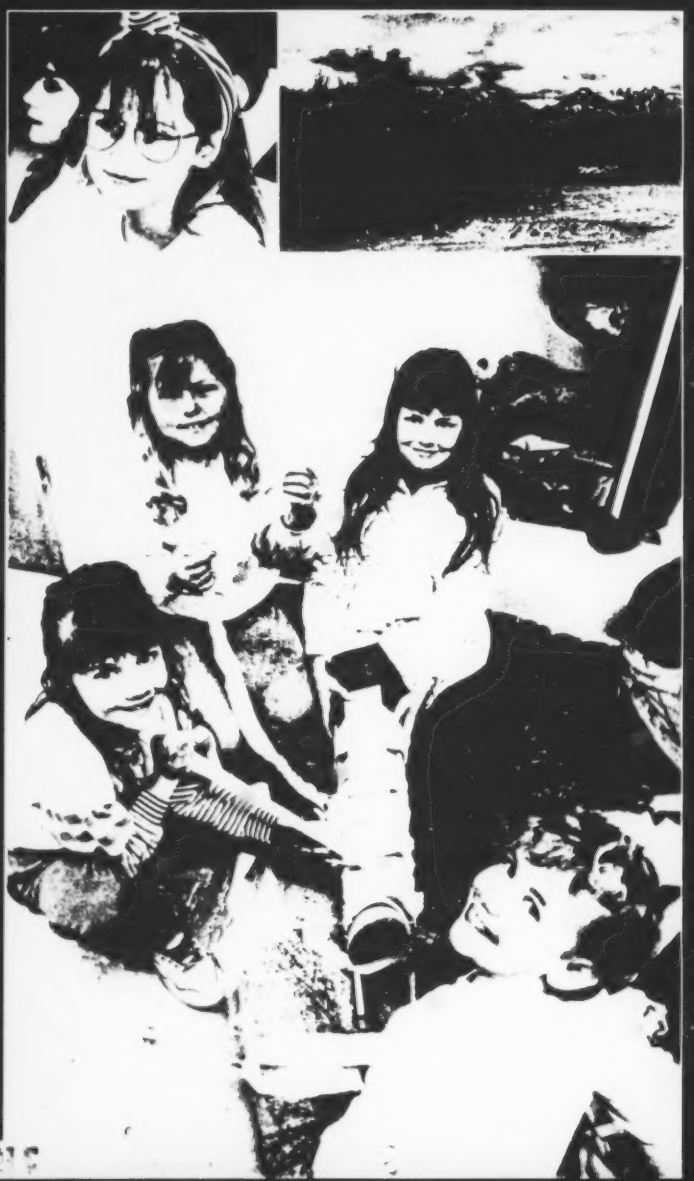

Northwest Regional Educational Laboratory

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A THREE-YEAR JOURNEY CONTINUES

This book is a celebration of rural education, rural educators, and rural communities. It provides an overview of rural health issues; it chronicles a rural health collaboration project; and it shares, through individual insights, a prescription for the successful development and implementation of rural health education programs.

INTRODUCTION

This book relies on the experiences, setbacks, and successes of six school districts in the Pacific Northwest that confronted their offerings in health education and decided that their students deserved better. It tells the stories of teachers, administrators, and other educators who teamed up with specialists from five universities, an educational service district, and a regional educational laboratory to create meaningful, comprehensive health education programs in their schools.

This was not a simple task. Health education is not a priority in our nation's schools. It has often been a token gesture in curriculum priorities, fragmented and inconsistent. It has not been taken seriously; it has not applied to us. Perhaps that is why we are so familiar with excuses for not implementing health education programs we know would be sound practice.

We all know school board members, superintendents, principals, colleagues, and parents who have dashed enthusiasm for a health education program by delineating all the reasons that it is unnecessary, unpopular, and unwise. Do these sound familiar?

- Health education is not a priority; it's not even one of the national goals.
- We already teach HIV/AIDS and substance abuse prevention.
- Rural life is healthier and safer than urban life. Urban districts need comprehensive health programs, but we already know how to take care of ourselves.
- Our traditional family values are strong and will provide children with the guidance they need.
- The community won't let us teach that.
- We don't have the resources or the training.
- We're already spread too thin.
- We can't fit another class into our day, week, month.
- There isn't the time, money, or support.

What these excuses really translate into is a disabling theme: *We can't teach that here.* This book tells how six rural school districts in the Pacific Northwest worked through those excuses and looked at what they *could* do to promote healthy lifestyles among their students. It seeks to provide rural educators with some of the tools they might use in developing a comprehensive health education program.

This book will not prescribe what rural schools should include in their curriculum, nor what resource materials to buy, nor how to run a health fair. Those decisions must be made at the local level by teachers, students, parents, and others who know best the needs of their communities.

Rather, it reflects a process critical to the successful development of comprehensive health education in rural schools, and realistically addresses conditions that exist in many rural communities.

Recurring themes of leadership, resources, and incentives weave their way throughout the chapters. Unique and innovative approaches are recounted. Most importantly, this book emphasizes the process that each district put in place to create a comprehensive health education program that met its needs. This process worked well for the people involved in the Rural Comprehensive Health Education Project. We believe that it will work for others, as well, and that it will help districts reach out beyond the schoolhouse to the larger community.

It was my privilege to be a part of this project. It provided me with the opportunity to work with the university and educational service district specialists in the region, to get to

"These rural educators are leaders. Their voices will continue to be heard beyond the time limits of the grant, because these rural folks have forged strong alliances at local, state, and regional levels. Collectively, we share and carry forward a common vision: healthy kids, healthy schools, and healthy communities for rural America."

Helen Sjolander, manager Rural Comprehensive Health Education Project

know some of the best educators in rural America, and to help able administrators, teachers, and nurses build locally tailored instructional health education programs. We saw health awareness grow beyond instruction into staff wellness, school environment, community involvement, and, above all, student well-being.

These six rural sites are models for their states and our region in both the process of curriculum renewal and the development of comprehensive health education. These rural educators are leaders. Their voices will continue to be heard beyond the time limits of the grant because the need for comprehensive health education is so great in rural areas and because these folks have forged strong local, state, and regional alliances.

Collectively, we share and carry forward a common vision: healthy kids, healthy schools, and healthy communities for rural America.

Helen Sjolander, Project Manager
Rural Comprehensive
Health Education Project
December 1, 1992

WE CAN'T TEACH THAT HERE

In 1990, six rural school districts embarked on a three-year effort to improve health education among children in remote communities in Alaska, Washington, Idaho, Oregon, and Montana. The districts were selected as part of the Rural Comprehensive Health Education Project, a three-year effort coordinated by the Northwest Regional Educational Laboratory (NWREL) in Portland, Oregon. Not only did the districts create meaningful health education for their students, but they also learned a lot about themselves and their communities along the way.

With the support of a U.S. Department of Education grant, the participants developed health education curriculum that was based on the needs and values of the communities in which these children learned, played, and lived.

The federal government supplied only the seed money for the Rural Comprehensive Health Education Project (RCHEP), as the three-year effort was called. The ideas, concepts, energy, and vitality that led to development of unique health programs at each of the six demonstration sites drew on the resources of teachers, administrators, students, parents, and others in the participants' communities. Team-building and teamwork were critical components in each of the sites' successful efforts to build health education programs.

Importantly, these local educators also worked closely with health and curriculum specialists from education service districts and universities to forge partnerships where skepticism and indifference had been the rule. During the program, each specialist served as a local consultant to one of the RCHEP sites, helping it put together a model health curriculum tailored to its unique needs. In the third year, the six schools shared their experiences and became resources for other schools throughout the Pacific Northwest.

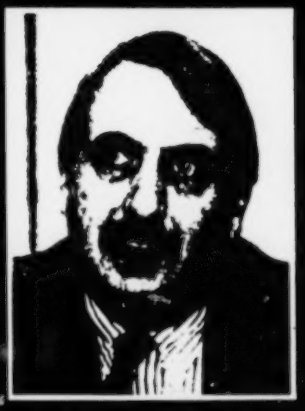
Helen Sjolander, RCHEP manager and a rural education specialist with the Northwest Regional Educational Laboratory in Portland, Oregon, coordinated project activities, fostered communication among participants, provided resources, visited sites, and served as host for several gatherings of teachers, principals, and specialists. Together, these educators collaborated to build health education programs that address the disparate needs of their communities and the compelling needs of their children.

The six districts involved in the RCHEP serve children in diverse and isolated areas in the Pacific Northwest — Tok, Alaska, the heart of the Alaska Gateway District; Seeley Lake, Montana; Carlton, Oregon; Umpqua, Oregon; Tetonia, Driggs, and Victor, Idaho; and Granger, Washington. Each experienced frustration, challenges, resistance, rewards, and progress on their independent roads to success. Above all, participants found that the power to promote change in their communities resided in the involvement of the people they were asking *to* change. A bottom-up, grass-roots approach was essential to the success of each of the districts in developing comprehensive health education curriculum that was broad-based and driven by the needs of the schools, the communities, and their children.

In each of the project sites, community acceptance of health education was a must. "We've come a long way in terms of developing a curriculum," notes Craig Kunz, principal at Teton Middle School in Idaho. "You have to understand that this is an extremely conservative community in terms of their value systems. But our health education program has been very well received. It's one that our teachers feel very good about, and it's one that our community has

"In our district, teachers got hands-on curriculum resources, and that helped motivate them, to get them enthusiastic about using the materials."

Barb DePaso, teacher
Alaska Gateway School District



"Health is more than the absence of disease, and a comprehensive program offers more than just knowledge. It tries to teach kids skills and attitudes, to teach them that they are responsible for their health and well-being."

Steve Nelson, director
NWREL Rural Education Program

adopted and accepted and feels very good about."

In choosing health curriculum, participants sought research-based promising practices, scope and sequence, coordination and integration with other subjects, use of basic educational skills, planned and ongoing staff development, rich learning resources, and outreach activities to the home and community.

NWREL provided resources and curriculum choices that ranged from top-of-the-line national models to inexpensive regional offerings to free information packages offered by the Dairy Council, American Lung Association, and others. "In our district," says Barb DePaso of Alaska Gateway, "teachers got hands-on curriculum resources, and that helped motivate them, to get them enthusiastic about using the materials."

Each of the districts sought a comprehensive approach to health education — one that encompasses growth and development, mental and emotional health, personal health, family life, nutrition, disease prevention and control, safety and first aid, consumer health, community health management, and information on alcohol and other drug use and abuse.

"Health," notes Steve Nelson, director of NWREL's Rural Education Program, "is more than the absence of disease, and a comprehensive program offers more than just knowledge. It tries to teach kids skills and attitudes, to teach them that they are responsible for their health and well-being."

That's a tall order, but not an insurmountable task. Good health, like good health education, must be practiced, pursued, and promoted in order to be effective. In *Health Instruction: An Action Approach*, Kime et al. cite the work of the Commission on Philosophy for School Health Education: "Truth revealed today may be the falsehood or misconception of the future. Information which is acceptable today may be obsolete tomorrow. Hence, the principal purpose to which health education should be directed is that of equipping students to cope with the inescapable facts of change by fostering the disposition to solve the problems which change inevitably produces and to develop the basic skills for doing so."

Consider this:

- Ten years ago, we didn't even know that AIDS existed. Today, it threatens young people everywhere.
- Twenty years ago, homeless children were considered troubled youth who were rebelling against their parents and other figures of authority. Today, the number of homeless and runaway children has skyrocketed, and we recognize that their rebellion is most likely a tool to cope with physical and sexual abuse.
- Thirty years ago, illicit drugs were rarely heard of or seen in public schools. Today, everything from pot to peyote and from crank to LSD is purchased by children everywhere — from inner-city neighborhoods to the most isolated communities in the country.

While some health issues seem to be in a constant state of flux, others appear to remain static. For example, we've struggled with the deadly effects of alcohol and tobacco in our health education curriculum for generations. Sex education, too, dates back to the 1920s. And convincing children of the merits of daily baths, brushing after meals, and routinely changing clothes is nothing new, either.

Effective health instruction, as Nelson noted, goes beyond providing information. When we honestly and openly communicate with children, provide them with reliable and sensible information, arm them with decisionmaking skills, trust them to make

decisions, and instill in them a sense of self-respect, we are really teaching them to lead healthy lives. They learn about choices, self-esteem, personal power to effect change, good citizenship, and giving back to their community.

In 1919, health education proponent Lucy Oppen wrote in *Teaching Health*, a booklet published by the U.S. Department of the Interior, "The end to be aimed at is not information, but action; not simply knowledge of what things are desirable, but rather the habitual practice of the rules of healthy living."

Those rules are forever changing, the resources for teaching them are constantly growing, and the methods for helping children to become active learners are continuously improving. By engaging in a process to develop a comprehensive health education program, we believe that rural educators and rural communities can rise above the disabling theme of *We can't teach that here* and provide their children with health education that leads to lifelong healthy behavior.

EXPLODING THE MYTHS

Poor health and poverty afflict children throughout the United States — from youth living in major metropolitan areas to children in small towns to those being raised in rural communities. But the public perception of rural children is often one of healthy lives grounded in hard work, loving families, and strong wills. Conversely, poor children often are associated with inner-city neighborhoods and minority youth. The stereotypes are a disservice to all the children who are growing up hungry, alone, abused, and poor. Life in the country is not lived atop Walton's Mountain. Increasing numbers of rural children are suffering, and their suffering has been largely ignored by researchers, policy-makers, and elected officials.

Volumes have been written about the physical and emotional health of urban and suburban youth, but there is a dearth of information that focuses on rural families and their children. As a result, society tends to view poverty, abuse, homelessness, teen parenting, and other problems as inner-city or urban issues.

"Rural areas have been largely ignored by underclass scholars despite the fact that the rural poor are more likely than the urban poor to be long-term poor," write William P. O'Hare

and Brenda Curry-White in *The Rural Underclass: Examination of Multiple-Problem Populations in Urban and Rural Settings*.

"Persistent poverty has been a central component of the underclass concept," the authors note. "People who fall into poverty for a year or two because of abrupt changes in employment or marital status are different from those who remain in poverty year after year."

The Children's Defense Fund, in *City Child Poverty Data from the 1990 Census*, reported that child poverty rose steadily since 1980 in metropolitan areas across the country. While the report focused on cities with high child poverty rates — among them Detroit, 46.6 percent; Laredo, Texas, 46.4 percent; and New Orleans, 46.3 percent — it noted that "86 rural counties have a higher percentage of children living in poverty than in the nation's poorest city, Detroit."

Others note that the economic, social, education, and health hardships faced by independent-minded rural families have accelerated. Consider these findings from recent national reports on children, health, and rural life:

ITEM: "Good health is essential to children's growth and development and to their future prospects," reported the National Commission on Children (1991) in its exhaustive report, *Beyond Rhetoric: A New American Agenda for Children and Families*. "While most American children are born and remain healthy, far too many are vulnerable to problems that lead to serious illness, disability, and even death. This country has the knowledge and the tools to save children's lives and improve their physical and mental health. Yet in recent decades, the nation's progress in improving child health has not kept pace with scientific knowledge and health care technology. . . . In particular, minority children, low-income children, *children who live in geographically isolated areas*, and those whose parents are poorly educated often have difficulty getting the health care they need" (emphasis added).

Among those groups, notes Margaret Heaggarty, director of pediatrics at New York City's Columbia University Harlem Hospital Center, rural residents often are hit hardest (Commission report, 1991). "The Harlem Hospital or the Cook County Hospital has many problems and few resources, but at least these institutions are there to do the best they can for the urban poor. In rural areas, they are often completely absent."

ITEM: The Children's Defense Fund (CDF) reported in 1992 that the

child poverty rate is higher for rural children than for nonrural children, and that rural children are poorer, less healthy, less educated, and generally worse off than their urban and suburban counterparts.

"The rural picture is not uniformly worse," notes Arloc Sherman, author of the CDF report, *Falling by the Wayside: Children in Rural America*. "Rural babies are less likely to be born at low birthweight than metro babies. Rural communities have lower homicide rates and are more likely to be rated highly by residents as good places to live.

"But for many urgent problems affecting children nationwide, far too little information is even gathered about rural children. Child abuse and neglect, substance abuse, mental health problems, and teen pregnancy are all pressing concerns for rural youths."

ITEM: Rural schoolchildren fared worse than nonrural children in 34 of 39 statistical comparisons for at-risk students, according to the 1990 report *National Study Regarding At-Risk Students* by Doris Helge. Among the findings:

- 17.7 percent of non-handicapped rural high school students were estimated to be substance abusers, compared with 10.1 percent in nonrural districts
- 12.3 percent of non-handicapped rural elementary schoolchildren were found to be suffering from depression and low self-esteem and prone to suicide attempts compared with 10 percent of urban and 8.5 percent of suburban youngsters. For learning-disabled and other mildly handicapped youngsters, depression was a problem among an estimated 16.9 percent of rural grade school pupils, but only among 9.5 percent of urban and 12.4 percent of suburban pupils
- 25.7 percent of non-handicapped rural high school pupils were considered sexually active, compared with 22.5 percent of urban and 20.9 percent of suburban students. Among mildly disabled rural high schoolers, 26.7 percent were sexually active, compared with only 15.3 percent of urban and 18.2 percent of suburban children
- 6.7 percent of non-disabled rural middle school youngsters were said to be involved in crime, compared with an estimated 5.6 percent in urban and suburban schools
- 12.7 percent of rural preschoolers without handicaps were considered victims of child abuse, compared with 11.9 percent in urban and 9.6 percent in suburban districts

"One of the most consistent features noted in the analysis of the survey data was that rural schools estimated higher percentages of children, both handicapped and non-handicapped, in the at-risk categories," wrote author Doris Helge of the National Rural Development Institute at Western Washington University in Bellingham.

CHANGING TIMES, CHANGING ATTITUDES

Times have changed in rural areas as rapidly and dramatically as they have in urban and suburban areas. Ask most anyone who attended school during the 1950s and earlier what they learned in their health education classes, and they might recite the four food groups, give a lecture on personal hygiene, or recall vague and uninformative discussions about "human anatomy."

To be sure, issues and anxieties existed for schoolchildren three decades ago, when the standard for the American family was being set by "Leave It to Beaver" and "Ozzie and Harriet." Questions about human sexuality, teen pregnancy, neglect

and abuse, and alcohol and other drugs were not created by the current crop of young people.

Indeed, the roots of public health education are embedded in such issues. As noted in *A History of Health Education in the United States* (Means, 1962): "The importance of alcohol education in the lives of American youth has been recognized since the first schools were established in the United States. It is equally obvious at the present time that school training should include materials concerning the effects of alcohol on the body, and on society in general (Brennan, 1949)."

Sex education, too, was promoted early in the first quarter of this century. *High Schools and Sex Education*, published in 1940 by the U.S. Public Health Service, was based on an earlier book by the same title prepared in 1922 (Means, 1962).

And while traditional classroom practice focused on personal hygiene to the exclusion of other health topics (Pine, 1985), researchers have long promoted a broader approach that has, through the years, included topics such as personal living, community living, sanitation, nutrition, physical activity, safety education, first aid, emotional and social health, education for family living, and occupational or industrial health. As is often the case, the lofty ideals of researchers have not easily or frequently made their way into the nation's classrooms.

In the past, health issues such as teen pregnancy, alcohol use, birth control, and the effects of dysfunctional families on the learning and social skills of their children were often ignored, condemned, or swept under the carpet.

In the 1960s and earlier, high school girls who "got pregnant" frequently disappeared from school, often under the guise of visiting a distant relative. Today, many high schools provide onsite child care for children of teen parents.

Alcohol abuse often was considered a rite of passage, something kids — usually boys — did on their way to adulthood. That attitude is still prevalent in many rural areas. But today, rural educators and communities are also on the front lines in efforts to instill kids with sound decisionmaking skills that guide them to alcohol- and drug-free lives.

Physical, sexual, and emotional abuse were largely unaddressed by schools, health professionals, and others in the education community. Today, educators, social workers, and others are recognizing that such abuse is frequently a common denominator in the lives of children who are at risk for alcohol and other drug abuse, sexual promiscuity, teen parenting, suicide, and other self-destructive behavior (Caudell, March 1992).

In some respects, society's attitudes about the problems of young people have changed, and there is an awareness that the needs of children must be addressed in the home, in the school, and in the community.

But we delude ourselves if we believe that we are now raising healthier, happier, safer, and fitter children. "Overall, younger children weigh more and have more body fat than they did 20 years ago," notes J. Michael McGinnis in the introduction to *The National Children and Youth Fitness Study II* (1987). "While virtually all early elementary school children take physical education (97 percent), only about a third do so daily. This is consistent with what we learned about the older children."

"In the rural districts, it's sometimes easier to teach controversial subjects than in larger districts. A local trusted person helps to dilute opposition and build support."

Jane Gutting
ESD #105
Yakima, Washington

DEADLY CONSEQUENCES

Each generation of young people has had to deal with potentially life-threatening diseases and choices. Some choices, like the use of tobacco, alcohol, and other drugs, span the decades. What has changed dramatically is the research-based information about the deadly consequences of ignorance, experimentation, and rebellion.

For example, tobacco use kills more than 434,000 people each year in the United States (Nystrom, June 1992) and is often introduced at an early age (*Healthier Youth by the Year 2000 Project*, 1990). Furthermore, as many as 60 percent of American youth already exhibit at least one of the prime risk factors for heart disease, the nation's leading killer.

"AIDS is now the sixth leading cause of death among youth ages 15 to 24. Over 5,000 children and young adults have died as a result of AIDS."

— A Decade of Denial: Teens and AIDS in America

And while alcohol remains the drug of choice among young people, other illicit drugs — LSD, crack, crank, and marijuana among them — have made inroads into communities in even the most remote areas of the country.

"It's lethal for kids to continue their involvement with alcohol and other drugs," says Stephen Bucknum, executive director of Rimrock Trails, an adolescent residential treatment center that serves 10 rural Oregon counties. "One way or another — if they continue to abuse — it will kill them."

Acquired Immunodeficiency Syndrome — AIDS — is spreading among teens at an alarming rate. "The number of teens who already have AIDS increased by more than 70 percent in the past two years alone, and AIDS is now the sixth leading cause of death among youth ages 15 to 24," notes a recent report by the House Select Committee on Children, Youth, and Families. "Over 5,000 children and young adults have died as a result of AIDS," notes the committee report, called *A Decade of Denial: Teens and AIDS in America*.

Such consequences are not lost on rural educators, where the willingness to address controversial issues may be dampened by actual or perceived community opposition. Often, opposition is brought by a small group of people making a lot of noise or is the result of not involving the community in the process. Involvement can be disarming.

"In the rural districts, it's sometimes easier to teach controversial subjects than in larger districts," notes Jane Gutting, director of interagency programs for Educational Service District #105 in Yakima, Washington. "It's easier because everybody in the community knows who the local health nurse is, and they trust her. So if she's saying a sexuality education program is needed, people believe her. A local trusted person helps to dilute opposition and build support."

Health issues such as the Human Immunodeficiency Virus (HIV) and AIDS have cast a pall over the lives of adolescents. "The perception that rural populations are somehow secure from the encroachment of [HIV] is both erroneous and perilous," note Doris Helge and Jonathan Paulk in a 1989 article in the *Journal of Rural and Small Schools*.

"It is erroneous because AIDS has spread across the face of the nation. . . . It is perilous because there seems to be a false security among rural populations; a belief that, as one rural interview respondent . . . stated, 'It can't happen here.' It can, and it does occur across rural America."

Such grim realities are not lost on rural educators. "I feel it's really important to discuss those issues," notes Kris Johnson, a health teacher in Seeley Lake, Montana. "Never before have kids been putting their lives on the line. But if you choose to have sex with several partners, you *are* put-

ting your life on the line. It's like playing Russian roulette."

In some respects, children in rural areas face similar issues as children in big cities and tree-lined suburbs. There are those who are physically, emotionally, and sexually abused; whose families are infected by alcohol and other drug abuse; and who are abandoned or neglected by those they desperately need to rely on and trust for their protection, comfort, and guidance.

"We've had some fairly severe cases of depression among some of our junior high kids," says Lisa Pena, a counselor at Seeley Lake Elementary School. "Some of these kids are raising themselves. They're trying to make all their own decisions about homework and drinking and friends."

There are differences, too, among rural, suburban, and urban areas. Tucked away on the backroads and country lanes of rural America are households without indoor plumbing, without electricity, without telephones, and without easy access to information about proper health care. Except for the schools, many children in these remote and isolated areas are cut off from the outside world.

DRAWING ON STRENGTHS

But rural communities are strong communities. They possess a hardiness and independence that is born of self-reliance and hard work in frequently harsh conditions. Their economies have become increasingly fragile, the result of corporate abandonment, environmental upheaval, and shifts in political policy that can sink rural fortunes as quickly as a natural disaster can wipe out a field of wheat.

Nonetheless, research consistently shows a strong sense of community, a willingness to pull together, and a high degree of satisfaction among those who live in rural areas. Those qualities can be drawn on in developing health education programs for children in these communities.

The need for rural educators and rural schools to develop effective and comprehensive health education programs is critical. The health of rural children can be transformed when schools develop comprehensive programs that address life's little miseries as well as those issues that they must confront to ensure their physical and mental well-being.

If offered in a comprehensive program that reflects local needs and values, health education can provide young people with the decision-making skills they need to lead productive, fulfilling, and meaningful lives in which they contribute to their families, neighbors, community, and country.

ANOTHER VOICE

Falling by the Wayside: Children in Rural America **is must reading for educators, elected officials, social workers, state and national policymakers, and others who care about the nearly 15 million children who live in the small towns and along the country roads in remote, sometimes isolated areas in the United States. The Children's Defense Fund (CDF) report probes the lives of rural children and their families and the devastating effects of unemployment, shifting economies, poverty, poor health care, public assistance, housing, child care, and education. What the CDF found are children living on the edges of despair. The following is an edited version of a report on the CDF publication.**

CHAPTER TWO

America's 14.9 million rural children face an enormous hidden crisis. On numerous key indicators, children in rural areas face a bleaker outlook than city and suburban children.

On numerous indicators of child well-being — family income, poverty, health, housing, education, child care, and teen pregnancy — the nearly one-quarter of America's children living in rural areas face bleaker odds than nonrural children.

"In a few respects, rural children resemble suburban children," says Marian Wright Edelman, president of

the Children's Defense Fund. "They are more likely to be white and are slightly more likely to have two-parent and working families than city children. But on other measures of fundamental well-being they fall behind just like urban children. They are poorer, less healthy and less educated, and are generally worse off than the average American child."

According to *Falling by the Wayside: Children in Rural America*, authored by CDF analyst Arloc Sherman:

1. Rural children are more likely to be poor (22.9 percent in 1990) than nonrural children (20 percent). They are less likely to benefit from public programs to alleviate that poverty.

Family unemployment rates are higher in rural America than nonrural America. Rural earnings are only three-fourths of nonrural earnings. Driven in part by a nationwide wage decline, rural child poverty rates have been at higher levels since the mid-1980s than at any time during the 1970s. Real yearly wages per rural job have dropped 7 percent in the last 10 years, while wages per nonrural job inched up. These trends drove up child poverty even while work effort among poor families rose: the share of rural poor families with at least one worker went up and is higher (65 percent in 1988) than for families in nonrural areas (57 percent).

A black child in rural America is more likely to be poor, and to experience extreme poverty, than a black inner-city child. The poverty rate among black children is deplorable across the nation, but is even higher in rural areas (53 percent) than in urban areas (47 percent).

Because eligibility requirements for public programs are skewed against two-parent and working-poor families, and because of transportation problems, rural poor families benefit less from public income and food assistance programs. Aid to Families with Dependent Children (AFDC) benefits per poor family with children in rural areas are about half the nonrural level.

2. Rural pregnant women and children face greater obstacles to health care than their nonrural counterparts.

Rural babies are more likely to be born to women who received late or no prenatal care, and white infant mortality is higher than in nonrural areas. Rural areas have only one-third as many obstetrical and gynecological specialists per capita as nonrural areas.

Rural children are less likely to have any health insurance compared

"Despite some apparent advantages, rural children are poorer, less healthy, less educated, and generally worse off than other American children."

to nonrural children and significantly less likely to have access to health services. They are more likely than children in cities and suburbs to go more than a year without a routine checkup.

3. Rural children are shortchanged when it comes to early childhood education services, school resources and quality, and youth development services.

Although mothers in rural areas are more likely to be employed (66 percent in an average month in 1990) than nonrural mothers (63 percent), child care is less available. Rural preschoolers are less likely to be in educationally oriented programs and rural child care workers have less education than nonrural child care workers.

Rural families are more likely than city or suburban families to be headed by a high school dropout, and rural high school dropouts are less likely than nonrural youths to get a GED. Rural high school graduates are less likely to go on to college than inner-city youth, and if they do enroll in college, are more likely to drop out.

High teen birth rates correlate to high poverty and low educational achievement. A greater proportion of births in rural areas are to teen mothers (15 percent of all births) compared to metro areas (12 percent). This is true for both white and black teens.

4. Millions of rural families lack affordable housing. Somewhat lower rural rents and home ownership costs are more than outweighed by much lower rural wages.

One in two rural renter households now pays more than 30 percent of its income for housing, even though federal standards say it is risky for families to spend more than 30 percent on housing costs. In 1990, in every rural county in the nation a family with a minimum wage income would have had to exceed this standard to rent an apartment at the local fair market rent.

Rural households are less likely than nonrural families to receive federal housing assistance. This has contributed to families doubling up, overcrowding, and homelessness for tens of thousands of rural children.

The rural picture is not uniformly worse. Rural babies are less likely to be born at low birthweight than nonrural babies, and maternal and child health in recent years has shown some improvement, especially in rural Southern states which traditionally provided the least access to health care for poor and minority citizens.

The United States has steadily changed from a mostly rural nation in 1900 to one only a little more than one-fifth rural in 1991. In fact, fewer and fewer Americans live on farms. By 1988 the number of children living on farms dropped to 1.2 million — about one in 10 rural children, compared to one in seven in 1970. The number of black farm children nationwide in 1988 was down to just 26,000 — less than 2 percent of the rural black child population.

Only one out of 11 rural jobs is a farm job. The remainder are in the service and manufacturing sectors, employment that resembles urban jobs but pays less and often is lower skilled.

The increase in rural child poverty in recent years has followed national trends and is not a result of the farm crisis of the mid-1980s. However, rural areas, especially in the South

where education investments have been lowest, are particularly vulnerable because their historic reliance on an inexpensive, unskilled, undereducated labor force fails to retain or attract jobs.

Three recent trends in the U.S. economy — projected shortages of entry-level workers, the increasing technological sophistication of the workplace, and the increasingly competitive nature of the global economy — mean that the nation will need all of America's children, including rural children, to be adequately prepared and educated.

"The continuing migration of young Americans to cities, combined with the ongoing expansion of metropolitan areas incorporating rural America, means many of today's rural children will join tomorrow's metropolitan citizenry and work force," Edelman says. "Rural areas may be isolated in many ways, but rural children's problems today will affect the entire nation in the 21st century. We cannot afford to let a single child languish by the wayside."

Falling by the Wayside: Children in Rural America *is available from the Children's Defense Fund, 122 C Street NW, Washington, DC 20001, for $13.95 postpaid. Note: Press copies available on request.*

REACHING OUT TO COMMUNITIES

Health curriculum is too important — and frequently, too controversial — a topic to be developed in a vacuum. Issues such as AIDS, sexuality education, and physical, emotional, and sexual abuse are of vital interest to the health and well-being of the entire community. Rural educators must reach out to their neighbors to defuse criticism, provide information, seek advice, and build support for their health education program. And that means reaching people where they live — in the towns and along the country roads and blue highways of rural America. It can be a time-consuming task. But, as the late singer-songwriter Harry Chapin noted: "It's got to be the going, not the getting there that's good." A strong and widespread community process is a critical part of building a health education program.

"Oh gosh! Just look at this lunch. It's full of fat!"

—A rural student takes a look at her lunch

Watch out! You teach kids how to recognize healthy living and they just might start holding you accountable. They may become critical of practices that they view as harmful to themselves, their families, or the public health. They may start bugging their parents about family lifestyles, habits, and behaviors. And those parents may come back at you, demanding to know why you're teaching their children to be so uppity.

"There are risks involved in having learners treat subject matter as personal and relevant to the current situation," states the American School Health Association in the *Journal of Health Education* (January/February, 1992). "They may focus to a greater than appropriate extent on themselves and their ills. They may become critical of their elders, of government policy, of business practices. If, as noted before, the subject matter of health education is established and taught in the context of the lives the students live and the society within which they live them, the educational process will contribute to the development of social values which will in turn maximize the development of individuality and independent thinking. The risk seems worth taking."

Participants in the RCHEP found that development of a comprehensive health education curriculum was beneficial in two important ways — one of them procedural, the other involving the behavior of students, families, and the larger community. "Health education is no longer a luxury, but a necessity," says Helen Sjolander, manager of the RCHEP. "As such, it must become a priority in education. Comprehensive school health education offers numerous benefits to those who undertake the process."

By now, you may be asking yourself, "Why all this talk about the process?" The short answer is: "Because it is critical to the success of your health education program."

Here are some of the benefits in developing a comprehensive rural health education curriculum:

A focused process: The process of integrating health education across the curriculum invites involvement by all staff in rural schools. As a result, health education maintains a high profile, a sustained focus, and ongoing accountability.

Planned program: Frequently, health education has been the victim of a hit-or-miss approach. As one rural health administrator noted: "We checked the *Weekly Reader* to see what our health lesson of the month would be." Teacher discomfort with health issues, lack of time, lack of resources, and other problems could derail poorly planned health education programs. A comprehensive program assures that health education is integrated into existing curricula areas across the grades with age-appropriate lessons. Critical, controversial, or sensitive subjects are included by design, not left out by fear or neglect.

Infusion, not an add-on: State departments, school boards, parents, and others rarely ask schools to do less. The pressure is for teachers and schools to take on more responsibilities with little consideration for the time, effort, and training involved. The comprehensive program model infuses health education into existing curricula, eliminating the need for another preparation or class period at the elementary level.

Inclusion and collegiality: A comprehensive process includes not only certificated teachers, but administrators, support staff, school board members, bus drivers, parents, cooks, and others. The process requires effective, open, and honest communica-

"A comprehensive program assures that health education is integrated into existing curricula areas across the grades with age-appropriate lessons."

tion. It places the entire staff on common ground, working toward common goals for the common good. And it includes inservice activities that focus on health instruction, health issues, and health resources. Open communication is both enabling and empowering and brings with it a sense of ownership and pride.

Routine: Sensitive topics are discussed as routine components of a comprehensive health education program, which lends perspective and defuses criticism and controversy. The comprehensive model also allows more time to discuss sensitive topics and to explain philosophy, approach, and need to concerned constituents.

Equally as important, schools, children, teachers, and communities reap the benefits of effective comprehensive health education, benefits which are both short- and long-term. They range from improved personal health to reductions in crime to fewer unwanted children to increased profits for business and industry.

"The primary purpose of modern school health education is to provide the knowledge and decisionmaking skills that will enable young people to make the connection between high-risk behaviors, such as sexual activity or drug usage or poor eating habits, and the potentially harmful health consequences," notes the National School Boards Association (NSBA) in *School Health: Helping Children Learn*. "Health education encourages students to take responsibility for their own futures by acting conscientiously today and establishing the health practices that will last throughout their lives."

10 Benefits of Comprehensive School Health Education Programs

An NSBA task force identified the following payoffs of good comprehensive school health education programs:

- Less school vandalism
- Improved attendance by students and staff
- Reduced health care costs
- Reduced substitute teaching costs
- Better family communication, even on sensitive issues such as sexuality
- Stronger self-confidence and self-esteem
- Noticeably fewer students using tobacco
- Improved cholesterol levels for students and staff
- Increased seat belt use
- Improved physical fitness

LOCATION FLAVORS ACTIVITIES

Each participant in the RCHEP developed health education that reflected their local needs and values. In addition, they developed programs — health days, staff wellness activities, pilgrim dinners, and others — that provided a focus on health in their schools and communities. The following narrative reflects some of the ideas, successes, activities, issues, obstacles, and solutions that each of the participants in the RCHEP faced.

Umpqua School District, Oregon

The Umpqua community nestles along the banks of the Umpqua River and the Calapooya Creek in rural Douglas County. The county contains nearly 3 million acres of commercial forest lands, including the largest stand of old-growth timber in the world.

Residents have been hard hit by the downturn in the forest products industry, which historically provided up to 30 percent of the jobs in Douglas County. Ranching, orchards,

field crops, and other agricultural products also play a key role in the economy.

In 1991, unemployment in Douglas County averaged 10 percent, compared to a statewide average of 6 percent. Employment in the lumber and wood products industries has declined nearly 20 percent in the past year.

The Umpqua Elementary School District is among several small, rural districts in the state that must either merge with a K-12 district or build its own high school by the fall of 1996.

Despite the imminent consolidation, Frank Cardiff, an Umpqua teacher and RCHEP site coordinator, says the benefits of participating in the project touched everyone in the 70-student K-6 district. The project, he notes, made it possible to:

- Make health the best-supported subject in the curriculum, with an extensive library of kits, models, and specialty curriculum.
- Conduct a Health Day each spring that raises health awareness, models healthy lifestyles, and provides exercises in physical fitness, first aid, wellness, personal hygiene, and a variety of other activities.
- Provide an all-school, community-wide Thanksgiving Dinner which features food selected, prepared, and served by children in the school. As a side benefit, the event has generated favorable media coverage for the school.
- Allow staff to attend the Seaside (Oregon) Health Conference, the only inservice activity offered in 10 years. Five of nine of the district's Health Committee members attended.
- Establish an all-school health fair.
- Develop a baby-sitting course for fifth and sixth grade students.
- Foster an environment where the school board, community, and staff worked together on an educational issue.
- Provide multicultural instruction by minority students from the University of Oregon.
- Establish a walking program for staff and students.

For students in rural America, some lessons in urban life can be beneficial. That's why Umpqua also decided to take a field trip to a nearby city for a lesson in pedestrian safety.

"The closest sidewalk to our school is at least five miles away," Cardiff says. "But our kids go into town. They go to the mall and park in a big lot. They have no conception of sidewalks, street crossings, or traffic. So we did a field trip into town and feel we probably extended some of their lives for some years as a result."

Umpqua's experience in the RCHEP involved building community and school board support, then weathering changes in the local political climate that included the resignation of the district's only administrator, an unsuccessful recall attempt of some school board members, and hassles over control of the grant that funded the rural health project.

"Despite our tribulations," Cardiff says, "all the individuals who have worked on or with this grant over the last three years have benefited. Every student who attended Umpqua received a greatly enhanced health curriculum. The entire staff was more aware, better supplied, and more motivated to emphasize health as a vital subject necessary for living in our world."

Seeley Lake Elementary School District, Montana

Highway 83 carves a 100-mile corridor through the Bob Marshall and Missions wilderness areas that rise above this rugged country in western Montana.

Tourists travel to Swan Lake, Seeley Lake, Salmon Lake, and other of nature's playgrounds to swim, boat, relax in lakeside cabins, and revel in the area's pristine beauty. Backpackers, hikers, hunters, and anglers find a bit of heaven in the Rocky Mountains that rise above this scenic highway that stretches — narrow and flat as a bowling alley — through remote communities and lakesides packed with deer.

The Seeley Lake School District serves about 220 children in grades K-8 in an area that stretches about 15 miles on Highway 83 north and south of Seeley Lake, a community of 1,000 residents 60 miles northeast of Missoula.

Staff at the school developed an innovative health education program that focuses on nine areas: personal hygiene, nutrition, substance use and abuse, environmental health, community health, emotional health, human growth and development, first aid, and safety.

Each month, a different staff member coordinates schoolwide activities on one of the topics. The health coordinator organizes a schoolwide program such as an assembly, poster contest, guest speakers, or other activity to focus attention on the health topic.

"The key to developing our health education program," notes Principal Dan White, "was to involve as many staff members as possible. We increased our committee size as much as we could to involve staff members as coordinators. I think the ownership was good because of that."

Coordinators also acquire and distribute materials, promote the health theme, evaluate the materials and program, and develop an inservice activity for other staff members. Teachers then incorporate lessons into existing classes at each grade level.

For example, kindergarten students studying environmental and community health may learn to identify the signs and symptoms of a cold, discuss disease prevention and reasons to keep their personal areas clean, and identify community health services and workers. At the junior high school level, students study how pathogens are spread and learn the causes of diseases such as AIDS and other STDs, cancer, and cardiovascular disease. The depth and breadth of each of the nine health areas studied increases as students advance through the grades.

When staff at Seeley Lake considered a health and safety program for its students, it looked beyond the basics. The program that has developed addresses the well-being of the students' physical, emotional, and mental health.

Throughout the school, health and safety lessons are reinforced daily.

For example, in one classroom children apply splints and slings to arms and legs injured in make-believe hikes through the woods. In another class, first graders talk about the 9-1-1 emergency system — how to use it, when to call, what to report. Later in the day, fourth graders talk about their fears, a discussion that wanders from fear of the dark to the difficulty of say-

ing "no" to friends intent on wrongdoing.

Middle school students discuss issues such as self-esteem, families, substance abuse, sexuality, the emotional consequences of sexual activity, communication, nutrition, cancer, and heart disease.

Teachers decided to throw out the textbooks on health education, and to instead build a resource library around the nine health topics. "We also decided that we didn't have the time to teach another subject, so we integrated health education into our existing curriculum," says teacher Kris Johnson.

The grant that the school received for its participation in the RCHEP helped to build the health resource library. The money also has provided staff development; paid for *The Great Body Shop*, a monthly curriculum that focuses on health education; allowed the school to purchase electronic blood pressure and body composition monitors; bought a skeleton for use in science classes; and purchased other materials.

Seeley Lake's commitment to its health program is evident throughout the school. Hallways are decorated with student art that reflects the monthly focus area. "What I noticed," says RCHEP specialist Kathleen Miller, "was stuff like 'Brush your teeth every day,' 'Don't share a toothbrush,' and 'Take a bath almost every day.'

"Remembering that we are in a poor rural environment, recognition of taking a bath almost every day is a major accomplishment," says Miller, associate dean of the school of education at the University of Montana. "Some of the families do not have running water, and taking a bath almost every day creates some real hardships."

Additional activities included:

- Visits from other school districts
- Increase in staff ownership due to topic coordinators
- Input from university and community on curriculum development
- Learning a process for curriculum development rather than just textbook adoption
- Pursuit of other grants, two of which were funded (motivated by success with the RCHEP grant)
- An increase in staff awareness of their own health ("To be effective health teachers, we have to be good role models," White says)
- A staff health screening
- A safety day, in which parents are invited to participate
- Integration of health, science, and guidance
- Increase in teacher willingness to handle sensitive issues
- Shift in focus of physical education to include more healthy lifestyle activities

Staff at Seeley Lake continue to serve as onsite consultants for other districts in Montana that are working on comprehensive health programs. They've even conducted a curriculum fair similar to the one NWREL provided for RCHEP participants.

"We did a Seeley Lake version of that," says teacher Kathy Thompson. "We had the hallway lined up with six or eight tables, by area, by grade — the whole thing. I think it really opened visitors' eyes to the fact that there is just a whole lot more out there than a textbook series that is available to them."

Teton County School District, Idaho

The Teton County School District hugs the border between Idaho and Wyoming, and is surrounded by picturesque mountains, meandering rivers, and jade-colored lakes. Some of the most rugged and breathtaking

"Teachers were saying, 'I have enough to teach. We can't add more classes.' They wanted an infusion of health education, not an add-on."

Kathleen Miller, RCHEP specialist, University of Montana

areas in the country — Grand Teton and Yellowstone national parks, and Bridger-Teton and Targhee national forests — all are within easy driving distance.

The district includes about 250 students at Teton High School, 230 students in grades 6-8 at Teton Middle School (both in Driggs), 230 students in the K-5 Tetonia Elementary School in Tetonia, and 251 students in the K-5 Victor Elementary School in Victor.

Teton's comprehensive health curriculum guide was developed with three major purposes in mind:

- To assist teachers in planning, sequencing, and implementing health education in grades K-12
- To indicate to teachers the health content covered in grades other than their own
- To provide information for parents and other interested school patrons about the health content in each grade in the district

The district's health curriculum details goals and objectives in 10 areas in coordinated and age-appropriate lessons for grades kindergarten through six. The areas of focus are mental and emotional health, personal health, substance use and abuse, nutrition, fitness, safety and first aid, disease and disorders, consumer health, community and environmental health, and human sexuality/family life, which is optional for students through fifth grade. Students in grades seven through 12 also study aging and emergency intervention.

A scope and sequence also was developed. Now, a new teacher, visiting educator, or parent can quickly and easily see the health education goals, objectives, and topics at each grade level. For example, the substance use and abuse health curriculum goal for kindergartners is to ensure that students "develop basic knowledge concerning the use, misuse, and abuse of drugs and medications." Objectives for kindergartners include knowing that all medicines are drugs, identifying persons who may give them medication, knowing that some drugs look like candy and that there are reasons for asking adults if it is OK to use an unknown substance, identifying proper storage areas for medicines and other potentially harmful items, and recognizing poison symbols and their meaning.

In the fourth grade, goals for substance use and abuse include gathering information about substances, their use and misuse (four objectives); understanding the importance of making responsible choices regarding the use of substances (five objectives); and becoming aware of substance abuse treatment and control (two objectives).

In the middle and high school years, students discuss the effects of tobacco, alcohol, steroids, illicit drugs, over-the-counter and prescription drugs; influencing factors such as advertising and peer group pressure; decisionmaking and refusal skills; social alternatives; resources; negative consequences; vehicle operation; and other issues related to substance use and abuse.

Each of the 10 areas in the comprehensive health curriculum weaves a similar path through the grades, making health education an ongoing part of student, teacher, and school life.

The district's "Philosophy of Health Education," developed as a result of its participation in the RCHEP, states: "Health must be viewed as a dynamic multidimensional measure of the quality of life rather than simply a freedom from illness. School health education is the vehicle that imparts knowledge, examines attitudes, and formulates lifestyle behavior that helps each student maximize her/his

potential for total well-being through an emphasis on wellness."

Among the other benefits listed by Teton County schools were:

- Health-related inservices delivered onsite by professors and graduate students from Idaho State University's Department of Human Resources
- HIV/AIDS education
- Increased staff awareness
- CPR certification for grades eight and 11
- DARE program in sixth grade
- Health class required in ninth and 11th grades
- Development of scope and sequence for health curriculum
- Addition of elementary physical education specialist
- Opening of lines of communications with state and higher education agencies

"Everybody recognizes the need for health in their life and in school," says Teton Middle School Principal Craig Kunz. "Our participation in the RCHEP has focused attention on health education as something important for our community. Now we have materials, and now we have resources specifically dealing with health education."

Gaining support and securing money for health education are not the sole keys to success. Staff also must learn the new curriculum and become skilled at teaching it. "We've had four inservices provided by Idaho State University that are directly health-related," Kunz says. "Many of our teachers had never had anything to do with teaching health education. We wanted to build their confidence and competence in their classroom presentations. And that has been a tremendous asset to us. We feel that now we can teach health as part of our curriculum."

Granger School District, Washington

The Granger School District focused much of its health education on the needs of children who work in the fertile fields of the Yakima Valley in central Washington. Granger, the largest site in the RCHEP with about 1,000 students in grades K-12, is one of several agricultural communities located along Interstate 82 between Yakima and Richland. The population swells in the spring, when families migrate to the area to work in the fields and orchards. Granger's per capita income is the lowest in the state.

The Granger Health Curriculum Team expanded and strengthened the first aid and safety strands in the school district's health education program to meet the needs of students who work in the fields with their families. (About 70 percent of the students in Granger are Hispanic.) All students in grades seven, eight, and nine are required to complete CPR certification and basic or standard first aid training.

The Granger School District has a high percentage of low-income students. In April 1990, 86 percent of the K-6 students received free lunches and 4 percent received reduced-priced lunches. "With the low socioeconomic level comes many health-related problems," notes Bonnie Seto, school nurse and chairwoman of the Granger Health Curriculum Team. For example, migrant workers' life expectancy is 50-plus years compared to the national average of 70-plus years. In 1989, the Yakima Valley was struck with a meningococcus epidemic, and in 1991 it was hit with a measles outbreak.

"Medical care is limited," Seto says. "Many doctors will not take medical coupons. Preventive care is a low priority. Personal hygiene is poor with many children, due to poor

"Health education is carrying over from one year to the next now because we know what is expected to happen in each grade. It's written down. Before, we didn't know."

Judy Hurlburt, teacher Granger School District

"The Health Curriculum Committee decided that it was important to expand our health education efforts beyond the walls of the classroom.... Health awareness and professional services were made available to our students, school families, and other citizens of Carlton."

Suzanne Farmer
child development specialist
Carlton School District

living conditions. There is a high percentage of single-parent families."

Health habits taken for granted in many communities — hand washing, toilet flushing, teeth brushing — must be taught and reinforced in Granger. "The health topics for hygiene, diseases, and nutrition have been enhanced in the curriculum to help students develop basic personal health skills," Seto says.

Yakima County also has among the highest teen pregnancy rates in Washington: 16 percent of the births are to teen parents. Sexuality education begins in the fourth grade for girls and continues for boys and girls through grade nine.

Granger was able to incorporate the four strands of the state health guidelines — wellness, personal and family health, environmental health, and community health — into the curriculum it developed as a result of its participation in the RCHEP. It also provides AIDS education in accordance with state requirements for students in grades 5-12.

During its participation in the RCHEP, the district developed a health education curriculum scope and sequence for grades K-6. Granger's health education program goals are to:

1. Provide a comprehensive (K-12) program that includes wellness concepts in the areas of physical, emotional, and social health
2. Emphasize the development of personal health skills necessary for living a healthy lifestyle
3. Develop an appreciation for individual diversity within a healthy global society

The curriculum guide details scope and sequence for 16 health-related topics: AIDS, drugs, anatomy and physiology, disease, mental health, nutrition, dental, hygiene, fitness, child abuse, relationships, sexuality, first aid, safety, health careers, and environmental health (see "Health Education Scope and Sequence, Grades K-6" in the Appendix).

"I think the best thing that's happening is that our own district knows more about health issues than before," Seto says.

Adds second-grade teacher Judy Hurlburt: "It's carrying over from one year to the next now because we know what is expected to happen in each grade. It's written down. Before, we didn't know."

Other benefits noted by Granger include:

- Use of community resources such as the Red Cross for CPR training and first aid classes
- Intermediate F.L.A.S.H. training
- High school students have contact with health in more than just health classes (for example, history)
- Teachers in a leadership role, disseminating and not just receiving information
- Ability to hand new teachers a usable health curriculum
- High school physical education teachers provide fitness classes and inservice for elementary teachers

Carlton School District, Oregon

Carlton is a small, rural town 40 miles southwest of Portland. Its 1,200 residents live near the foothills of the Coast Range Mountains. Carlton is a largely agricultural and logging community that also supports a grain mill, seed-cleaning facility, glove factory, and meat-packing plant.

A fair portion of the Carlton school population is transient and lives in low-income, substandard housing. Carlton's population is not culturally diverse, which sets it apart from other surrounding communities of similar size.

"Many of our families are without any sort of medical or dental insurance coverage, yet they do not qualify

for public assistance," says Teresa Clinton, a teacher in Carlton Elementary School. Twenty-two percent of the school's 375 students qualify for free lunches, and 11 percent qualify for reduced-price lunches.

"The Health Curriculum Committee decided that it was important to expand our health education efforts beyond the walls of the classroom," says Suzanne Farmer, a child development specialist. "We involved the community in our Health Fair, where we were able to offer a dental screening, blood pressure check, cholesterol screening, body-fat analysis, and spinal alignment. Health awareness and professional services were made available to our students, school families, and other citizens."

In Carlton, advocates for change in health education focused first on getting the support of school staff. "Our staff has been very involved in this project," says Clinton. "As a result, we have seen many lifestyle changes as well as valuable resources provided for their wellness."

A staff survey helped identify strengths and weaknesses in the existing health curriculum, and provided the foundation for purchase of materials and other resources. "We just couldn't believe there were so many resources out there," Clinton says. "We took materials back to the teachers, surveyed them, and asked what they would like to beef up their curriculum. We provided other curriculum materials and they selected the things they needed."

"We have fantastic materials now," notes Rich Moberg, physical education and health teacher. "We have a life-size skeleton and models of the mouth that teachers can check out. It's hands-on things for the kids. All the classes had fun naming the skeleton, and using it has enriched our program."

Students have benefited by having a relevant and active curriculum that looks at wellness instead of disease, Moberg adds. The RCHEP provided money to purchase much-needed classroom resources, and a school health fair and a bloodmobile visit have become annual events.

"One problem we've run into," says Moberg, "is that we've had to take kids out of PE for health in the middle grades. The kids don't like it. This is the wrong attitude if we're trying to get health off the back burner and into the limelight. It's been a frustration for us." Plans are under way, Moberg notes, to propose classroom-based health instruction for children in sixth through eighth grades.

In Carlton, health education has become a community affair. Adults as well as students have participated in health screenings, bicycle safety programs, and bloodmobile visits. The RCHEP grant provided funding to offer a broad-based comprehensive health education program.

"The grant has helped us realize our potential for positive improvements," Farmer says. "And there is a lot of enthusiasm to continue providing quality health education to all."

Benefits noted by Carlton include:

- Dreaming Drug-Free Student Group
- Baby-sitting classes for seventh-graders
- Staff wellness classes (aerobics and walking activities)
- Health-related assemblies
- Kindergarten screening in the fall for speech, hearing, vision, and academics
- First aid/CPR classes for staff and community
- Health Fair

"We just couldn't believe there were so many resources out there. We took materials back to the teachers, surveyed them, and asked what they would like to beef up their curriculum. We provided other curriculum materials and they selected the things they needed."

—Teresa Clinton, teacher
Carlton School District

"We have two-teacher schools that teach K-8. We have three-teacher schools that teach K-12. So our teachers are teaching everything, and the resources have to be there for them."

Rita Abel, teacher
Alaska Gateway Schools

Gateway School District, Alaska

Alaska Gateway's eight schools enroll about 500 students in communities as remote as Chicken and Eagle and as relatively cosmopolitan as Tok, the state's first major city along the Alaska Highway that winds its way through British Columbia and the Yukon Territory.

Enrollments include fewer than 25 students at Tetlin, Tanacross, Mentasta Lake, Border, and Dot Lake schools; 41 students at Eagle Community School; 98 students at Walter Northway School; and 246 students at Tok School. Another 38 students attend school through the Alaska Gateway Correspondence. Some of the schools are inaccessible by road during the long winter months, and inclement weather can also prevent air traffic from landing or departing the air strips that line the countryside. Telecommunications is critical to education in Alaska, and even tiny Dot Lake School, which serves 16 students in grades 5-12, is equipped with a space-age satellite dish.

In schools where one or two teachers work with students from all grade levels, selection of materials and resources becomes critical. "We started our process by forming a committee made up of school and some community representatives from all the sites in our district," says Rita Abel, a teacher at Tok School who, with colleague Barb DePaso, served as RCHEP co-coordinator for Alaska Gateway schools. "We wanted an outcome-based curriculum, so we did a lot of writing of our curriculum guide."

The committee incorporated existing materials into its evolving curriculum, and established 9 major conceptual areas for health education, as well as courses in hunter/gun safety, outdoor survival, and family planning skills. Student outcomes were developed for each of the areas, then materials and resources were linked to each of the outcomes by grade level.

A matrix was developed that lists the health topics and the resources that should be used at each grade level (see "Health Resources Scope and Sequence" in the Appendix). "This has been one of the selling points in our curriculum guide," Abel says. "Regardless of which grade level they're at, a teacher can look at the grid and see the materials they are going to be using. And the materials are listed under each student outcome.

"That took time to develop, but it was necessary because we serve such diverse communities. We have to meet such a variety of needs — from Tok, where there is a teacher for every grade level, to the two- and three-teacher schools in our district."

Alaska Gateway is a sprawling district that is larger than some states. "We have seven schools widely spread apart plus a correspondence study program for those who do not have access to a school," DePaso says. "Some schools are accessible by road, others you can fly into in the winter or, in the summer, you can take a boat."

Educating staff about the health curriculum and informing parents and others in the communities throughout the district also was critical. "It's so very important to educate the parents," DePaso says. "When I was doing violence prevention, I had a parent who really didn't want her son to be a part of it. She didn't know why she objected; it was just one of those areas where she thought, 'My son doesn't need this.' But when I explained the program to her and she looked at the material, she had no problem with it."

Abel agrees. "People think it's easier to address controversial issues in rural areas, but I would disagree. We are in a very conservative area in

Alaska, so you have to do a lot of public relations. You have to make the curriculum and resources available to parents.

"We tried to pull in all those people who might be negative about or opposed to our curriculum," Abel says. "We didn't want things to blow up in our faces at the last minute. We involved the community in our health fair so they could see what we were doing and talk to us about it. Public relations and public information were critical parts of our efforts."

Providing resources for teachers to use in their classrooms also was a critical component in the development of health education curriculum. "Our district really found that if we want to have a successful program or improvement, we have to provide hands-on resources for the teachers," Abel says. "It's so much more effective if a teacher can come to an inservice and walk away with materials"

Alaska Gateway School District developed a comprehensive health education program that includes teacher pre- and post-evaluation as well as student self-evaluation of the key topics in the curriculum.

"Health education addresses a diverse range of topics which focus on the total person, integrating the physical, social, emotional, and environmental components of human experiences," states the district's final report on the RCHEP. A comprehensive health education program, the report says, will:

- Foster the development of self-awareness and self-esteem
- Develop an awareness of the interdependent role of health in the lives of individuals, families, and the community
- Nurture the development of attitudes that place a high value on optimal health
- Provide students with the knowledge and skills required to set goals, make informed decisions, and solve health problems
- Acquaint students with health-related careers
- Enable students to deal effectively with change and take increasing responsibility for their own health
- Model healthful faculty/staff behaviors and healthful school environments

Other benefits noted by Alaska Gateway schools include:

- Health fair for students, staff, and community
- Effective and popular dissemination process
- Arctic survival training
- Successful buy-in of parents on sensitive issues
- Technology component with health education incorporating software for health
- Outcome-based portfolio format

The value of being involved in a health education project that spans five states cannot be underestimated. The RCHEP created linkages that provided support, promoted creativity, and enhanced accountability. "Everyone was working toward a common goal," Abel says. "And while we are all different, it helped for us in Alaska to know that we were going to have to face everyone else involved in the project. We didn't want to fall behind. Each site, in effect, motivated the other sites, and that helped all of us to be successful."

MISERIES LARGE AND SMALL

Comprehensive health education involves more than a laundry list of classes developed by well-meaning but over-extended teachers. And just because your school provides alcohol and other drug education and meets state mandates for HIV/AIDS instruction does not mean that you're anywhere close to changing the behaviors of children, some of whom suffer life's little miseries on a daily basis. Sure, you want your health education program to lower alcohol and other drug abuse, lower teen pregnancy rates, and provide healthy alternatives for kids. But a lot of children also need to learn the merits of bathing their bodies, brushing their teeth, and changing their clothes on a regular basis.

You're proud of your school's recently adopted health education curriculum: It hits the tough topics — drugs, alcohol, sexuality, HIV/AIDS — as well as life's little miseries, those nightmares of childhood that can affect a student's ability to concentrate and learn. But is your curriculum comprehensive?

Well, you're certainly on the right track. But comprehensive health education involves more than an expansive list of topics that may or may not be presented in a coordinated, integrated, and logical manner that spans the years from kindergarten through graduation.

"Above all," notes Helen Sjolander, a specialist with NWREL's Rural Education Program, "comprehensive health education focuses on behavior change. It provides students with reliable information, emphasizes development of critical thinking and decisionmaking skills, and gives them the opportunity to make healthy choices in their lives. Sound decisionmaking abilities will lead to lifelong healthy lifestyles."

The key to sound decisionmaking, adds Elizabeth Newhall, a Portland physician who is active in issues affecting youth, is in nurturing, teaching, respecting, and trusting children. "If we empower our children from Day One to make decisions, trust that they can make decisions, and accept them when they do, then I bet that they'll make better decisions."

Another key ingredient of a comprehensive rural health education curriculum is that it reflect local needs, concerns, lifestyles, and vision. Learning how to treat burns makes sense in rural Montana, where many people heat with wood stoves. Dealing with the effects of prolonged darkness makes sense in Tok, Alaska, where the sun sets in the fall and rises again in the spring. Teaching children about machine safety makes sense in Tetonia, Idaho, where young people help to harvest and store the area's potato crop. The key is that the things children learn must have relevance to their lives.

The development of a comprehensive health education program should be well thought-out and deliberate, and should involve teachers, administrators, school board members, students, parents, and others in the community. While school health programs need to reflect local needs, comprehensive programs share three common components:

- Direct instruction on disease prevention, wellness, and life skills and behaviors
- Health services provided by the schools or as a referral system to community resources
- A healthy school environment (a smoke-, drug-, chemical-, violence-, and hazard-free campus) that is nurturing and supportive, and where

"Even though the topics may be controversial, meet your community head-on. They really aren't your enemy as much as you may think. They have their opinions, but what they really want is to hash these things out."

Bonnie Seto, teacher, Granger School District

adults provide healthy role models for students.

Definitions of comprehensive school health programs have evolved in response to the emerging and varied needs of children. While the RCHEP focused on development of *health instruction* in the classroom, all pilot sites sought to include community resources, health services, and staff wellness in their school health programs.

Curriculum teams from each of the sites studied the expanded concept of comprehensive school health as described by Diane Allensworth and Lloyd Kolbe in "The Comprehensive School Health Program: Exploring an Expanded Concept," an article in the *Journal of School Health*. They suggest that educators consider eight distinct components in developing a comprehensive program: health instruction, services, environment, physical education, food services, counseling, integrating school and community health promotion efforts, and school staff wellness.

KNOW YOUR COMMUNITY

The challenge for rural educators in defining their comprehensive school health program is to creatively identify community resources. Farmers, loggers, orchardists, fishing guides, teachers, homemakers, shopkeepers, and millworkers are the pool of volunteers in rural areas. They are available because *you* know who they are and how to tap into the pulse of the community, not because they are listed in a county service directory or through an agency.

"The way to communicate with folks in Granger is to sit across the table, have a cup of coffee, and show them what's going on with the curriculum" says Jane Gutting, an RCHEP resource specialist. "We didn't need a lot of committee meetings.

"We would give them the curriculum and ask them to go out and share it with everybody they knew, then to come back and tell us where the red flags were. It was a casual kind of acquaintance, but when we took the curriculum to the school board for adoption, those community members were there. They were all sitting there nodding in agreement because they had all seen the curriculum before."

Adds Bonnie Seto, a teacher in the Granger district: "Even though the topics may be controversial, meet your community head-on. They really aren't your enemy as much as you may think. They have their opinions, but what they really want is to hash these things out."

The potential for controversy should not be minimized in developing rural health curriculum. Sex education, AIDS prevention, contraception, alcohol and other drugs, physical and emotional abuse, and mental health are loaded with potential controversies that can bushwhack even the most seasoned educator.

And it is not only the high-profile topics — AIDS, sex, drugs, contraception — that draw the ire of parents and others in the community. Lessons in stress management, critical thinking, and decisionmaking have been attacked as promoting "New Age" or "Far Eastern" religions by residents in states from Washington to Florida to Maine. At its annual summer institute this year, the American Association of Health Educators focused on strategies for managing community conflicts that arise over health education.

KEYS TO DEVELOPING CURRICULUM

Comprehensive health education programs incorporate the eight components described by Allensworth and Kolbe with the understanding that the examples promoted in urban-based school health literature are not readily identifiable, available, or necessary in rural districts. It also is important to keep in mind that all eight components need not be introduced in the first three years of a project. A deliberate, organized process that leads to curriculum which reflects local needs is most important.

"We made a decision not to include some of the Kolbe and Allensworth guidelines, not to include some of the Center for Disease Control stuff," says Gutting. "It's not that we forgot them. We were aware of them, but ours was a process of choosing from the generic literature, focusing on what works for us, then filling in with other health activities and lessons that we felt were necessary in our rural setting."

Participants in the RCHEP emphasized that rural health curriculum development needs to focus on the specific needs of the particular community. "We didn't look at the technical aspects of the health curriculum as a certified master or doctoral-level person would look at it," says Rita Abel of Alaska Gateway School District. "We looked at it from a practical, local standpoint on how it would best meet our needs."

Such a local focus also invests staff in the adopted curriculum. "We didn't look at what we were supposed to do," Frank Cardiff of Umpqua School District says. "We looked at what we thought we needed. That's how we got the ownership." Adds Tony Whitley, a health teacher in the Granger School District, "It's important to recognize that rural is positive, being small is positive. Change is often made more quickly because of our size."

Five of six districts involved in the RCHEP included an employee wellness component in their comprehensive school health education program. Lunchtime walks, aerobic exercise programs, resource libraries, and other activities are becoming fixtures in schools as well as corporate headquarters.

Ideally, the comprehensive health education program:

- Starts in kindergarten and builds coherently from one grade to the next through grade 12
- Employs a research and evaluation component to reach its goals
- Includes teacher training
- Is coordinated by a professional health educator

Participants in the RCHEP identified critical ingredients for success in creating a comprehensive health education curriculum. They include:

Community involvement: Involve the community in your health education program from the first stages of development through review, revision, and renewal. The controversial nature of many health-related issues can be addressed and defused through open and honest communication among various community groups, factions, and individuals. The process you choose is the most important component in developing comprehensive health education. An open, honest, and proactive process that encourages and solicits community involvement assures widespread support.

Leadership: Most rural districts do not have curriculum specialists or directors, duties that most often fall on the administration. Involving the entire staff provides opportunity for equitable input, staff ownership, and

"We didn't look at what we were supposed to do, we looked at what we thought we needed. That's how we got the ownership."

Frank Cardiff, teacher Umpqua School District

human resources to complete the project. Administrators can then serve as project leaders and catalysts for change.

Administrative support and leadership are keys in developing health education programs. Effective leaders involve their staff in the concepts, discussions, decisions, and other responsibilities of schoolwide change. "And," notes a participant in the RCHEP, "leaders trust."

Superintendents in rural, isolated districts often rely on outside expertise in areas of curriculum development. "Health is a curriculum issue that doesn't have a home," says Alaska Gateway Superintendent Spike Jorgenson. "We were looking to tie it with science, or looking to tie it with physical education."

Through the RCHEP, Alaska Gateway teamed with Nancy Murphy, an assistant professor of education and curriculum specialist at the University of Alaska/Fairbanks. "We looked for somebody to help from the college level because we wanted someone who truly had the expertise in curriculum development, someone who could work with our faculty," Jorgenson says. "We have some teachers who are interested, but Nancy has really carried the ball. My role is to kind of start things. If they fly, fine; and if they don't fly, that's fine too. I don't keep the motor running."

Effective leadership results in curriculum that is practical and useful in the classroom, two essential outcomes when the goals include behavior changes and sound decision-making skills that improve the health and well-being of children.

Teamwork: The notion of teamwork is twofold: First, it involves fostering a sense of unity and camaraderie among all staff as your district pursues comprehensive health education. Second, it involves the building of a health advisory team consisting of administrators, teachers, support staff, community members, and others who work directly to develop, promote, and implement your health education program in the school and community.

Areas of Comprehensive School Health

1. Curriculum and instruction
2. School health services
3. School health environment
4. Food services
5. Counseling
6. Physical education
7. Worksite health promotion
8. School-community integration

An effective team presents a united front to the school board and community, flattens the lines of authority, reduces the burden of responsibility, and avoids the isolation that can develop if only one or two people are responsible for developing a health education program.

School board members and district administrators need to be mindful of the time and commitment it takes to develop comprehensive health education. Providing release time, meeting time, and paid summer or weekend time is critical for staff members already spread thin with teaching and other responsibilities. Staff development and training also are essential when new methods, ideas, and curriculum are introduced. Do not expect curriculum development to be successful if staff are expected to volunteer. Staff time and effort must be rewarded or compensated. Trade-offs and informal negotiating will produce a reasonable, cost-effective process and allow for a reasonable amount of volunteer time.

School board support: Community and school board members have consistently endorsed the health education programs in schools involved in

the RCHEP. The success of individual projects may be attributed to the participant's ability to gain and maintain school board, parent, and community input and support.

HEALTHY CHILDREN ARE BETTER LEARNERS

Research consistently shows that healthy children are better learners. Yet few schools or districts provide comprehensive health education to the nation's 47 million elementary and secondary students.

Clearly, most schools offer some sort of health instruction, but the quality, scope, and relevance varies greatly. Nationwide, only 5 to 14 percent of the country's 83,000-plus schools provide comprehensive health education, according to the National School Boards Association.

It's little wonder, with health so low on the priority list, that students fare poorly on tests in the few states that assess health and physical education. In Oregon, results of health tests in 1992 showed few students scored above grade-level expectations, and 33 percent of third-graders scored below grade level.

"This tells us that health needs additional attention in the primary grades," says Oregon School Superintendent Norma Paulus. "Our assessment makes it clear that our children are not getting enough information about nutrition and elementary health care. We're becoming increasingly concerned about the lack of organized physical activity for our younger children in particular."

The Oregon assessment included survey questions about student behavior. Results show that many students are not getting enough nutritious food, sleep, and exercise. For instance:

- 34 percent of eighth-graders skipped breakfast at least three times a week
- 61 percent of 11th-graders got seven or fewer hours of sleep on a typical week night
- 41 percent of 11th graders follow a regular exercise program only sometimes or not at all

In many ways, comprehensive health education remains a poor stepchild to other curriculum areas. "In the last decade of budget reductions, health and physical education programs have often been the first to go," Paulus says. "These short-term solutions will have long-term consequences to the health and welfare of our society."

TIME, RESOURCES, AND THE "M" WORD

Building a comprehensive health program is no small task. Support must be built from the bottom up, and from the top down. Communication among teachers, support staff, administrators, school board members, parents, and the rest of the community is critical. The "M" word — money — is essential. Staff development is fundamental to your efforts. Fitting all the pieces together requires vision, time, resources, and good old stick-to-itiveness. But rural communities are resilient communities. And when all the forces of those communities take on a task, chances are pretty good that they will succeed.

So you want to begin the process of developing a comprehensive health education curriculum in your rural school district. You've talked with a couple of other teachers who are supportive, and you know the need exists. The few health classes offered in your school are irrelevant, unconnected to any other curriculum areas, and offered as time allows.

But what should you do next? What kind of support will you need? What kind of resources? How do you go about making others aware of the need and getting them to enlist in the effort?

The Northwest Regional Educational Laboratory and the six sites involved in the RCHEP identified three major areas that, if addressed in a systematic and deliberate manner, will help ensure a successful project.

A WIDE BASE OF SUPPORT

Without initial strong, vocal, and vigorous support from the school administration, undertaking a project of this magnitude should not be considered. Support also must come from school staff members, who should be brought on board at the earliest possible time. Teachers, nurses, counselors, support staff, and others need to know what will be expected of them and how they will contribute to the success of the project. Communication is a key component throughout the process, especially in the beginning.

RCHEP participants forged partnerships and created health education teams to review materials, brainstorm, and share ideas and concerns. Widespread involvement is critical, especially when developing curriculum in a non-required area.

"When we're dealing with non-required areas of curriculum development, the leadership is going to be different from some of the required areas," says Jane Gutting, an RCHEP specialist who worked with the Granger School District in Washington. "There is no authority that goes along with voluntary curriculum development. The leadership in our project came from the grass-roots level and from the health teams."

Teams were composed of teachers, support staff, community members, and others. Primarily, it was teachers who took the leadership role, Gutting says. "The reason they were empowered to be leaders is because of the bottom-up leadership that evolved. The school board basically got out of the way and said, 'This isn't required, but we've got the resources in our area to do it, so go ahead.'

"Team members became decision-makers on how the grant money was going to be spent. They didn't have to go through a lot of lines of authority. And the team is not made up of a lot of people with credentials in the area that you are developing," Gutting says. "You need desire and, the most important thing, you need people who are willing to get their hands dirty. You have to get dirty when you're in the field."

Additional support is essential. Communication with the community and school board during the initial stages of the project helps ease the inevitable discomfort that some people experience when change occurs. Their inclusion in the change process is critical.

Local advisory and curriculum review committees with a broad base of representation also can enlist support. For example, Granger's Health Curriculum Team and Review Panel included three parents, three clergy members, five teachers, the school nurse, two principals, an additional community member, the district special programs director, and a regional health specialist. Success often is the

"My high school administrator gave me a budget. There had never been a health budget before. It's not much, but as soon as you get a budget then you become a department. So you become something."

Tony Whatley, teacher Granger School District

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result of negotiation and compromise among the various constituents involved in the change process.

A variety of departments in state government, educational service districts, and higher education also can provide assistance. Since state mandates sometimes trigger curriculum change, support and guidance from state departments at an early stage is important.

Often, state and regional agencies are unaware of the specific needs of rural districts, but will respond to direct requests for assistance. "You need to call us," says Peggy Holstedt, health education promotion specialist with the Oregon Department of Education. "A lot of time we don't know what the needs are, and I'm not allowed to go out to a district unless I'm invited. I can guarantee you: If you don't call, we won't come. Just ask. Don't make our decisions for us by not calling. I think that happens a lot."

Restructuring local curriculum without using appropriate guidelines and available resources is a time-consuming process that could be derailed before it ever gets out of the station, but each agency is more than willing to provide support to help get the job done. Small, rural schools need not use their isolation as an excuse.

MONEY AND OTHER RESOURCES

Let's talk about the "M" word. Money is, after all, a critical component when restructuring curriculum, and a school district must realize that there are costs involved. Teachers look to the district for financial support that helps them to develop and implement the new curriculum in a timely, coordinated, and professional manner.

The RCHEP found that teachers need release time to work on curriculum restructuring and extended contracts to pay for the extra time they spend on the project. The message from administrators and school boards must be loud and clear: "We value your time. Your time is worth money. You are a professional and you will be paid for your professional expertise."

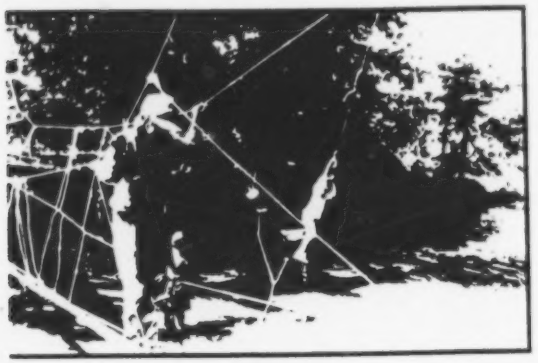
School districts also must realize that a restructured curriculum creates the need for additional or new materials. The RCHEP identified a variety of resources, some of them costing a great deal, some free, and many moderately priced, that can provide a foundation for curriculum reform. However, resource materials need not cost the district an arm and a leg. "I maintain that you can have a health curriculum from free and inexpensive materials because of the quality of stuff that's out there," Gutting says. "You don't have to have a textbook."

Inservice activities are also critical to prepare teachers for the changes they are being asked to make and to give them the tools to teach a reformed health curriculum. Teachers understand the importance of health education, but they often are reluctant to deliver critical information to students in areas for which they have not been prepared. The sites chosen for this project demonstrated that when teachers are provided information and materials, they are much more enthusiastic about the project.

Ongoing financial assistance confirms the district's support of health education and validates staff efforts. "My high school administrator gave me a budget," notes Tony Whitley of the Granger School District. "There had never been a health budget before. It's not much, but as soon as you get a budget then you become a department. So you become something."

Money is not the only resource necessary in developing or restructur-

ing health curriculum. Among the human resources to consider are staff, school board, and community mem-



bers; administrators; higher education health specialists; state departments; local, state, regional, and national agencies; university and public libraries; others in higher education; and grant writing information from state departments, the federal government, colleges, and universities. NWREL also can serve as a sounding board for initial planning and as a referral source.

AWARENESS

Be aware of what you already do that is effective and relevant. Most schools incorporate more health education into a school day than they realize. What already exists needs to be identified, organized, and supplemented.

Be aware of the health issues and problems in your community. Confront health issues that currently exist as well as those with the potential to disrupt, disable, or infect your children, their families, or the community. Be proactive by looking to the future, but also ground yourself in the present by attacking head-on the existing health issues in your area.

Be aware of how to begin the process of curriculum review and renewal. Discipline, structure, accountability, and deadlines create an atmosphere for an orderly process of change.

Be aware of the financial, human, and material resources necessary to adequately support your project. This level of reform cannot and should not be undertaken in a vacuum. The greater the involvement of specialists and others, the broader and more comprehensive the outcome.

Be aware of the indispensable need for inservice training for the staff responsible for delivery of the program. Continued communication and information sharing with the community at large is also critical. Their inclusion in such activities as health fairs and wellness screenings makes them more aware of the program and allows for their participation.

Be aware of the need for skilled collaboration among all agency, community, and school stakeholders. All interested parties need to have input, and all input needs to be seriously considered.

Perhaps most important, be aware that health education must take a front-line position in schools. It is not a fad or a passing fancy. Its importance will not be diminished by the passing of time. Comprehensive rural health education cannot be treated as an "add on" subject or as an afterthought. It must be recognized by everyone for its singular and critical importance to the well-being of not only your individual communities, but of society as a whole.

ARE WE THERE YET?

Participants in the RCHEP developed an 11-step checklist that is helpful in determining if your health education program is effective. The key, though, is in remembering that health education, like health information, needs to be updated continuously, and that it must be promoted and

practiced on a daily basis. Here are the components that determine whether your district has an effective health education program:

1. The district health education program reflects local values and expectations
2. There is a written districtwide health curriculum scope and sequence guide, including the mention of available and appropriate resources and materials for each grade level and area of emphasis
3. There is an emphasis on behavior change and making healthy decisions about lifelong health habits
4. There is ongoing outcome-based assessment of the program components
5. The staff accept the health curriculum, are enthusiastic about the entire health program, and teach their portions of the health curriculum
6. There is an ongoing district oversight committee to monitor and update the district health education program
7. The entire staff engages in wellness activities, modeling healthy behaviors and choices
8. The school district staff take an active interest in the well-being of their community
9. There is community involvement and support of the district's health program
10. There is an active school/community health advisory board
11. There is school board support and fiscal allocation for an adequate district health program

There is another critical issue involved in development of health education: How do you know when your health curriculum is comprehensive? Again, the RCHEP participants identified some key components:

1. The instructional curriculum includes each grade level (K-12, K-8, etc.) in your district
2. Instruction should include the following areas: health promotion, disease prevention, emphasis on self-esteem, decisionmaking, nutrition, family life, growth and development, consumerism, physical fitness, and safety and survival (If any of these areas is excluded, your curriculum development should have justified not including these areas or blending of others)
3. Evidence in the written curriculum that the primary focus is on the five aspects of good health: physical, mental, emotional, social, and spiritual

"Schools could do more perhaps than any other single agency in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more

productive lives," wrote Allensworth and Kolbe in the article "The Comprehensive School Health Program: Exploring an Expanded Concept." "Indeed, more education and health professionals are becoming interested and involved in working with schools to protect and improve the health of students, and to protect and improve the health of school personnel as well."

A FIELD GUIDE

Developing a comprehensive health education program in a rural district is an involved process that requires a sound foundation of support prior to launching your effort. It is fraught with pitfalls, dead ends, detours, and soft shoulders. But the results — meaningful health education that reflects community needs and values — are well worth the effort. RCHEP participants developed an action plan based on their experiences that can minimize hazards and prevent your efforts from getting derailed.

"There is no heavier burden than a great potential."

— *Linus*

Participants in the RCHEP created meaningful health education in their small, rural, isolated school districts. In order to do so, they confronted many of the disabling themes that can prevent districts from reaching their potential. Today, they stand out as leaders throughout the Pacific Northwest in rural health education development.

They are spreading the word about their success and providing a framework for developing health education at conferences, workshops, and other school districts. The key to success is in the process.

"I went to a neighboring school district to help out," says Tony Whitley, a teacher in the Granger School District. "First they had to evaluate where they were before they could decide where they want to be. And they were very pleased to see something in writing about our curriculum. They are looking over some of the other curriculum materials as well. I have a presentation next week at Yakima School District where my kids go to school. But I'd like to see more school districts call us. I'm not sure they know what we've gone through."

The RCHEP has developed a structured guide that can help others develop health curriculum in their rural districts. Again, the guide focuses on process, not product, because we believe that your health education program should reflect the needs and values of your community. "It doesn't help for us to go tell people that this is our curriculum," says Seeley Lake Principal Dan White. "It does help to tell them what we did to develop our curriculum. It really is a story of process, not of product."

The process is enabling, empowering, and effective in rural districts anywhere. The rest of this chapter describes that process. (See the box on page 47 for a summary of its components.)

Establish Health Education as a Priority

Whether restructuring an existing program or developing one to be offered for the first time, a comprehensive health education program must first be recognized as a priority by the principal, superintendent, and school board. Health education must be seen as a primary area of concern, not supplemental to physical education or a response to state mandates. Early endorsement from the district gives health education visibility and credibility, which signifies its importance in the entire school program. Throughout the district, the attitude needs to be one of "Yes, we need to do this," and "Yes, we understand that support for this curriculum development in health education is as important as support for any other academic area," and "Yes, we understand this includes a continuing budget commitment because health education is important."

Establish Leadership Structure

Primary responsibility for leadership may come from your administration (superintendent, principal, curriculum director), from your staff (teacher, nurse), or from a combination of the two. Early identification of the leadership is critical. Regardless of who is identified, the leadership must be held in high regard by staff, administrators, school board, and community members involved in the process. Knowledge in the area of health education is desirable, as is a commitment to comprehensive health education programming. The ability to skillfully communicate, di-

"It doesn't help for us to go tell people that this is our curriculum. It does help to tell them what we did to develop our curriculum. It really is a story of process, not of product."

Dan White, principal
Seeley Lake School

rect, lead, learn, and pursue tasks is essential. Leaders also must be willing to serve as advocates of comprehensive school health education in the district and community.

Research the Literature

Health education information is readily available, and the knowledge base is growing at an ever-increasing rate. Before starting, everyone involved in the program planning process should be aware of the vast array of topics, information, presentation methods, and effective practices upon which comprehensive health education draws. Because comprehensive health education program planning and curriculum reform is often a first-time effort (unlike curriculum review in other academic areas), an understanding of comprehensive school health education, including its underlying philosophy, content areas, and program components, is a strategic prerequisite to action.

Form a District/Community Task Force

One of the essential preliminary steps is the formation of a task force or advisory board that is politically astute as well as committed to health education. The committee should be large enough to include representation from all important stakeholders, but small enough to be functional. Potential committee members include representation from the school board, staff, high school physical education and/or health education staff, medical community, religious community, parents, local institution of higher education, educational service agency, local businesses, nonparents, and state departments of health and education. Broad representation and an open process help to defuse sensitive or controversial subjects and assure support. Committee members also will be expected to actively promote health education in the schools and community. Leadership for this committee should be the same as, or work closely with, the primary leadership identified previously. The committee chairperson is in the best position to act as liaison between the school district, which must complete the final product, and the rest of the community, which must approve and endorse the product.

Establish Baseline Information

Most districts will have a health education program in place, but some will have to start from scratch. Regardless of what exists, it is important to start with a systematic needs assessment that includes, but is not limited to, finding information about the current scope and sequence of the health education curriculum, state health education curriculum requirements, services available to the district, and the community and school environment. Determine the issues that are important in your community. In some areas, water safety may be a prime topic, while in others, hunter safety or winter survival may be relevant. Each assessment must take these local issues into consideration when planning the scope and sequence in order to make it a meaningful and functional curriculum. Careful

selection of advisory board members should help ensure a realistic view of what exists as well as break down any denial of problems. Advisory board members also should be able to identify areas of potential concern for the community. (An example of a needs assessment matrix for curriculum scope and sequence, the "Health Education Program Assessment Tool," is included in the Appendix.)

Write Goals, Objectives, and Assessment Criteria

Any curriculum plan should rely upon state guidelines as a cornerstone. By starting with these guidelines, a case can be made that the restructuring or development of a health education curriculum will ensure accreditation for the district/school. Major strands or topic areas which are generally included in a health education curriculum can be found in the scope and sequence examples in the Appendix. We suggest you review a variety of established curricula, but don't adopt any curriculum as a total package. The key is to adapt curriculum and resources to meet your needs, not to adopt any single text or generic program.

Assess Needed Resources

Once you have established a scope and sequence for the comprehensive health education program, you can turn your attention to selecting resources. In some cases, these resources may involve budget items (for example, books, special programs, videotapes, workbooks, models). Local volunteers also are available to work with classroom teachers to enhance the health education program. A dental hygienist, beauty operator, forester, emergency medical technician, Life Flight helicopter crew member, and others can help give life to your program and involve local residents in it. Choosing resources for your program will become clearer once you have completed your scope and sequence and written your goals and objectives. Be creative about locating resources: not all good information is found in a textbook. As a matter of fact, if the program is truly comprehensive, it is unlikely you will find any single textbook that will adequately cover all the information you need.

Select the Curriculum

Review as many curriculum materials as you can before making any final selections. Many companies will send samples of their products for your review. The final curriculum selections should be made by the teachers responsible for delivering this comprehensive health education program. The advisory committee should also be involved in material review. Again, the adoption of a single textbook often thwarts any effort you may have made to adapt this curriculum to your local needs and environment. An eclectic selection based on assessed needs is a far better approach. Check the Appendix under "Curriculum Categories" for an idea of how to separate curriculum materials into logical and workable categories. This allows for a much more orderly process in making choices. Be sure to talk with publishers regarding the availability of additional support materials. Publishers often have excellent suggestions on how to make the best use of their materials. Some will send company representatives to your dis-

trict to provide orientation or inservice to staff members.

Provide Staff Development

In many cases, staff members have little or no formal training in health education. You've spent a lot of time and involved a lot of people in the process of developing your health education program. Equal commitment should be extended to staff who are responsible for working on a daily basis to help students learn how to lead healthier lives. Among the characteristics to look for in staff responsible for teaching health curriculum are:

- A degree in health education
- State endorsements for health educators
- University course work
- National CHES certification
- High interest
- Inservice training
- Veteran teachers who have widespread community support
- New teachers with a health background or training who have mentors and can rely on the solid support of the administration and their peers

Often, staff members who support health education feel unprepared to teach the subjects. One of the key components to successful implementation of a comprehensive program is to help all participants feel comfortable with the subject areas for which they are going to be responsible. Inservice or staff development can take place by inviting curriculum experts to the school/district; by sending key staff members to state, regional, and national meetings; by sending staff members to specialized health education workshops; and by promoting individual memberships and participation in professional organizations. Health education specialists often are available from universities and colleges at a minimal expense to the school. University graduate students can sometimes arrange and conduct inservice activities as part of their advanced studies. Continuing education courses also may be arranged for credit. Staff members should model healthy lifestyles. This may include participating in staff wellness programs that have been initiated as part of the comprehensive health program.

Action Plan for Developing a Comprehensive Health Education Program

- Establish health education as a priority
- Establish leadership structure
- Research the literature
- Form a district/community task force
- Establish baseline information
- Write goals, objectives, and assessment criteria
- Assess needed resources
- Select curriculum
- Provide staff development
- Implement curriculum, services, and wellness
- Monitor and assess the program
- Get long-term commitment and involvement

Implement Curriculum, Services, and Wellness

Once your school's comprehensive health education program has been developed, careful implementation can take place. If your school's previous experience in health education has been minimal, you may not be able to implement the entire program at once. Start with what you are already doing well as a basis for implementation, then add to the program in a systematic fashion. Protect your

chances for success by keeping everyone informed and involved with the process. Too much change too quickly can overwhelm staff and create resistance to even the best-planned programs. Invite parents to participate or observe and conduct community open houses, fitness/wellness nights, and health fairs. Special displays in the halls or on classroom bulletin boards and articles in the local newspaper also help keep the public informed. Keep momentum going by keeping what you are doing visible to everyone.

Monitor and Assess Program

Implementation of the program is not the final stage. Rather, the process is open-ended and dynamic. Once you have begun implementation, you must monitor its progress. Are staff members who are responsible for certain goals and objectives actively meeting these objectives? Is the advisory committee occasionally meeting to evaluate progress? Are students' behaviors changing in the direction of program goals? Is the program making any impact? What kind of changes do you have to make before you present a particular topic again? What additional resources do you need? Are there any resources that did not work? Where are the gaps or omissions in the scope and sequence? Should any goals or objectives be added? Are any goals or objectives misplaced in terms of grade-level expectations? These are but a few of the potential questions you may wish to ask as the program progresses. This questioning, monitoring, and assessment process should be an ongoing part of the program. You must be accountable for what you say the program will do for the students, and this accountability will not be evident without assessment.

Get Long-term Commitment and Involvement

With proper assessment and the results from that assessment, you will be able to go back to the school board and community and show that implementation of this comprehensive health education program has had immediate results. Long-term commitment from the school administration and community is not only desirable, but necessary.

The best way to assure such support is by showing how your program has benefited students in your schools, and by extension, how it has enhanced the quality of life in your community. The administration must be convinced that this program has its rightful place in the curriculum renewal process along with reading, mathematics, music, and other programs. Continued involvement of the advisory board is paramount. This is one sure way of maintaining the open communication so vital to the success of the program.

As with anything else, once a habit has been formed, it is hard to break. Make health education a good habit, that is impossible to break.

BUILDING BRIDGES, SEEKING SUPPORT

You've worked hard to provide the health education that your schoolchildren need. But there are times when you feel inadequate, unprepared, and ill-at-ease with the health education program in your school. You lack resources, and are unsure of what is available to you. You're not alone. Let's face it: Teacher education programs provide a general background in a lot of areas, but most give short shrift to health education. Who can you call on for help? Participants in the RCHEP found that health specialists from educational service districts and higher education institutions provided invaluable insights as well as words of encouragement and support.

Historically, the relationship between rural school districts and higher education or state departments has ranged from cool indifference to strained politeness to outright animosity.

Rural educators cringe at the thought of another state or federal mandate that has little relevance in their community. "The small, rural school increasingly is finding itself between a rock and a hard place," wrote Paul Nachtigal in the 1982 report, *Rural Education: In Search of a Better Way*. "It clearly gets its support from and is expected to serve at least in part a rural community culture. It is also inextricably a part of an urbanized, one-best-system structure.

"From the local community perspective, the school that was once 'theirs' is seen more and more as an outsider as more rules of the game are determined by state and federal mandate."

Nobody likes to be told what to do. Yet time and again, rural communities have endured state mandates or federal edicts that may make sense in urban and suburban areas, but bear little resemblance to the day-to-day difficulties of educators and students in rural communities.

"Policy decisions affect small schools, but they are not based on the needs, desires, or uniqueness of rural communities," notes Steve Nelson, director of NWREL's Rural Education Program. "Policy geared to urban and suburban schools can and does have detrimental effects on rural schools." Forced consolidation, mandated curriculum, and dictated standards can all damage the ability of a small, rural school to serve its students and community.

"The function of a rural school goes far beyond that of educating children," Nachtigal wrote. "It is not only a piece of the local social structure, it is often the hub that holds the community together."

Rural educators in the RCHEP set aside any distrust they harbored for "outsiders" and teamed up with college professors and educational service district specialists to forge effective health education programs in their communities.

Health education specialists in the RCHEP, though, provided more than advice and direction. "It was not our job to write the curriculum," says Jane Gutting. "It was our job to identify some research-based components and to let folks know what some of those components were. The schools and districts integrated those resources locally in the ways that best fit their needs.

"It was our job to provide expertise, and sometimes to pump them up. I heard that in a lot of my conversations with local team members. They would say, 'Help me to refocus. Pump me up.' The specialists were the people who they could call up and talk with about gut-level expectations and interpretations of the grant.

"So the expertise was important," Gutting says. "But the other part that was important was the nurturing from the specialist."

What the rural educators needed was assistance in planning their health education program, in filling in the gaps, and in providing support. "We do not need someone to write the plans for us," one participant says. "We do need someone to help us plan because we don't have curriculum specialists at the rural level."

Specialists found a variety of ways to provide assistance to their sites, says Nancy Murphy, assistant professor at the University of Alaska/Fairbanks and an RCHEP specialist. In Alaska Gateway, teachers were able to earn college credit for their RCHEP work. "We were able to provide credit for the people participating in

"We had to spend a bit of time overcoming, or working toward diminishing, the credibility gap that institutions of higher education have. But I was really grateful that this grant provided the stimulus, sort of the catalyst, to get us together."

Nancy Murphy, RCHEP specialist University of Alaska/Fairbanks

the committees," Murphy says. "Sometimes the committee work was designed as a credit course, a curriculum design course of sorts. Sometimes the inservice presentations were designed so that all teachers in the district could obtain credit for their participation. That was a strong motivation for people."

Specialists also needed to be sensitive to the issues faced by teachers in remote areas and to be a part of the leadership team that created the environment for change to occur. For example, rural educators often have a variety of duties — coaching, administrative responsibilities, continuing education, and multiple daily preps among them — that prevent them from adding on another class.

Kathleen Miller, an RCHEP specialist, picked up on that message early in her work with Seeley Lake School District. "Teachers were saying, 'I have enough to teach. We can't add more classes.' They wanted an infusion of health education, not an add-on.

"The Seeley Lake folks were perfectly willing to integrate these topics into their curriculum, but they needed the materials and resources to do so."

NWREL provided a vast array of health education resources for RCHEP participants to review and use in their districts. Materials, though, must meet the local needs of rural educators and schoolchildren. "We were impressed with the materials," says Judy Hurlburt, a teacher in the Granger School District. "We were at a point where we were going to look at materials. But before we did that we wanted to also look at our needs. So we did a needs assessment. We took a look at where our strengths and our weaknesses were. Then we looked at the materials to see what filled those needs, and we went from there. We provided inservice, purchased materials and pulled it all together for the teachers. And that process continues."

TAKE THE TIME

Specialists also must be sensitive to the time it takes to establish trust in rural communities, not just with the school staff, but with town folks as well. Their role should be low-profile, but high-impact. Among the worst things you can say to people in rural districts is: "I'm from out of town, and I'm here to help you."

Local connections build support for change in rural communities, says Jim Girvan, chair of health education at Idaho State University and an RCHEP specialist. "From my perspective, the teachers in Teton have been in the community for a while and are seen as natives. They have a lot of credibility with the parents."

Credibility is a key element in gaining community support for health education. "If those who are teaching these topics have credibility, then you can literally do anything," Girvan says. "You can talk about any subject, say almost anything, and the kids will get excited by it. They'll go home and tell their folks, and they'll say, 'Oh, you did that today. That's great!' But if I were to go into the community, or if the district were to hire somebody from the outside to do this, it would take a lot longer to build that trust."

Credibility is often an issue among staff and administrators in rural districts. "We had to spend a bit of time overcoming, or working toward diminishing, the credibility gap that institutions of higher education have," Murphy says. "But I was really grateful that this grant provided the stimulus, sort of the catalyst, to get us together."

"If those who are teaching these topics have credibility, then you can literally do anything. You can talk about any subject, say almost anything, and the kids will get excited by it. They'll go home and tell their folks, and they'll say, 'Oh, you did that today. That's great!'"

Jim Girvan, RCHEP specialist Idaho State University

Fitting into rural, often conservative, communities can provide the credibility that other "outsiders" might lack, adds Lorraine Davis, an RCHEP specialist who worked with the Umpqua School District in southern Oregon. "This group just wasn't ready to go," says Davis, who also is vice provost for academic personnel at the University of Oregon. "They were a bit skittish about health topics in Umpqua.

"There's a big split there — a supportive group and another group that says, 'You're taking away our rights as parents to teach our kids about washing and brushing their teeth.' "

Divided communities can adversely affect classroom teachers. And that's what happened in Umpqua. "The teachers were never a problem," Davis says, "but they needed to know that they were not over-stepping the bounds with the parents."

The conflict eventually diminished, but it took a lot of work up front. "The visit I made with the school board early on was critical," Davis says. "We needed to get through their distrust of me for them to realize that I was OK from their perspective. The fact that I had a rural background was a key factor in building that trust."

Building bridges to higher education, state departments, and educational service districts can open doors to presenters for staff inservice and provide activity kits and other resource materials. At the university level, Miller notes, new and exciting resources — books, videotapes and audiotapes, presentation kits — are continuously flowing across professors' desks. "What I have done," she says, "is set aside a corner of my desk to stack these things up. When I have an opportunity to go to Seeley Lake, I just pick them up and take them with me. I become a resource and provide some of the material that they might not otherwise have access to or know about."

Gutting says rural districts often are overlooked by state policymakers because of their isolation, size, and lack of political clout. But, she adds, rural districts get jobs done. "When you only have a small building full of teachers and you're in their face all the time talking, then things get done," she says. "And that's the wonder of working with a small district.

"If at the state level you want to be winners, invest in rural education. Rural communities are easy to work with, and they are filled with strong leaders."

"They were a bit skittish about health topics in Umpqua. There's a big split there — a supportive group and another group that says, 'You're taking away our rights as parents to teach our kids about washing and brushing their teeth.' "

Lorraine Davis, RCHEP specialist University of Oregon

WHAT WE LEARNED

In just three years, six rural school districts in the Pacific Northwest went from offering meager health education programs to becoming leaders in their respective states. The focus of this project has been on rural students, rural educators, rural schools, and rural communities. A few years ago, the state of Oregon adopted a slogan that says: "Things look different here." To a large extent, that message applies to rural communities across the Pacific Northwest. For years, their voices have been ignored by policymakers who embraced a "one best system" for schools that frequently trampled on the spirit, uniqueness, and independence of rural communities. But the RCHEP celebrated the strength and vitality of rural communities, the goodwill of rural neighbors, and the concern that these independent-minded rural folks have for the future of their children.

In health education, as in other curricular areas, teachers assess, evaluate, and monitor student progress. Often, though, teachers are left wondering — health lessons taught in a classroom today may not take hold until the students are in their late teens or well into adulthood.

Ideally, teachers at the six RCHEP sites would have loved to document dramatic declines in unhealthy student behaviors that reflected healthier lifestyles and stronger decision-making skills. But one of the frustrations of teaching is that results are not always immediate. Teachers never really know how many girls did not get pregnant, how many children did not get lost on a wilderness hike, how many kids did not get hurt in an accident, or how many children did not begin to use alcohol or other drugs.

"Are we making a difference?" asks Wilda Ball, a health education teacher at Teton Middle School. "Teachers wonder that until the day they die. Did I make a difference in my classroom? Did I keep one child from starting to take alcohol or did I keep one child from starting to smoke? I don't know. How do you evaluate that? I go home nights and worry about that."

In the day-to-day lives of children in the schools, though, teachers noted small but significant changes in student behaviors: They saw it in the classroom, on the playground, and in conversations with kids and their parents. For example, at one school, increasing numbers of children took advantage of the newly installed salad bar in the cafeteria. At another school, students were more aware of personal hygiene. At yet another site, kids were more active during recess.

At Seeley Lake, Kathleen Miller relates how one lower-grade student said that his family had agreed that it would be a good idea to try to change underwear twice a week when they also took a bath.

"I believe the importance is that the family had a discussion about a health issue," Miller says. "That's a big change. I think the program will have an impact not only on the kids, but on all of Seeley Lake."

The RCHEP, though, was not really about changing student behavior. That was frequently among the goals of teachers and others who developed the health education programs at the six sites throughout the Pacific Northwest.

To a large extent, the RCHEP focused a spotlight on rural education, rural educators, and rural communities. "We wanted to see what curriculum renewal looked like in small, rural districts," notes Steve Nelson. "We know that the urban models don't fit. So what would work in rural schools? What steps would you go through to develop health education that fits your needs?

"The second thing we wanted to know," Nelson says, "is what happens when we remove the three big excuses — the here's-why-we-can't-do-it kind of things."

The most common obstacles to health curriculum development fell into three general categories: lack of time, lack of money, and lack of resources. "So we provided money for teacher release time, health education specialists to support your efforts, and curriculum resources that went beyond *Growing Healthy*, which costs too much for most small, rural districts," Nelson says.

"Interestingly, I'm not sure if those three factors were as critical as we may have thought they were to begin with. What came through loud and clear is that leadership at the local level is critical to the success of these projects. You can have all the money and all the time and all the resources in the world, but if you don't have

"Are we making a difference? Teachers wonder that until the day they die. Did I make a difference in my classroom? Did I keep one child from starting to take alcohol or did I keep one child from starting to smoke? I don't know. How do you evaluate that? I go home nights and worry about that."

Wilda Ball
health education teacher
Teton Middle School

"I think that the bottom line — the thing not to forget — is that it's critical to get team members who believe that they themselves can create a health education program and carry it forward."

Leslie McBride
RCHEP health education specialist
Portland State University

somebody advocating, advocating, advocating, it won't happen."

Leslie McBride, an RCHEP specialist and assistant professor at Portland State University, adds that local health curriculum teams also need to know that their work is valued and that their voices are heard. "All of the sites agree that to really get the program going, it took a team that was committed and people who truly felt that they could make a difference.

"The key word here is empowerment," McBride says. "And I think that the bottom line — the thing not to forget — is that it's critical to get team members who believe that they themselves can create a health education program and carry it forward."

Participants also learned that geographic isolation need not mean a lack of contact with other educators. Collaboration among the rural sites, educational service districts, higher education institutions, and NWREL was essential to the success of the project. "Philosophically," McBride says, "I believe that collaborative models of this nature — educational labs, college and university folks, and folks from the districts — are very important. It has been a pleasure to be involved in this type of model.

"I've learned, or relearned, a great deal about school health curriculum and management of rural education as a result of participating in this project. I'm grateful for this."

At the start of the RCHEP, the six rural participants provided varying degrees of health education: from "nothing" in one district, to *Weekly Reader*-prescribed lessons in another, to hit-and-miss lessons, to struggling to meet state mandates. Today, the districts have adopted health education programs that fit their local needs, mirror their communities' values, benefit the children in their schools, and serve as models for others in their state.

What isn't readily visible is the increased awareness of and involvement in health issues. "As time passed, I witnessed a definite increase in confidence and sense of expertise in health education," says McBride. "I think that when it comes to rural education, they have come to appreciate just how much expertise they actually have. This is all wonderfully empowering. Also, I think that the project has served to diminish their sense of isolation."

The health education programs created as a result of the RCHEP have been institutionalized at the participating sites. "A year from now," says Rita Abel of Alaska Gateway District, "I see us continuing to have health in-services, continuing to support our health education, and continuing to be a resource to other districts. We now have commitment."

Craig Kunz, principal at Teton Middle School in Idaho, says that health

education at his school should survive changes in administration. "I think there is a real wellness concern in our system now," he says. "I think a rural community has a high priority for health, the environment around them, and the need for good health to survive. There is now a strong health education program in place in our elementary and middle schools.

"I do think that there has to be continued administrative support at all levels," Kunz adds. "But I also think that with strong people in the classrooms, the program will continue."

The true success of the RCHEP was in the process it identified for developing health education programs, Nelson says. "We never in any way intended to create some sort of National Diffusion Network-validated, wonderful health education curriculum that we could disseminate widely.

"There is no one curriculum. But there is a process. And the bottom-up, grass-roots, collaborative, locally developed kind of approach probably makes the most sense. If you really want to keep your health education program off the shelf and in the classroom, you need to build it from the ground up locally.

"So was the program a success? Yeah, I think it was a delightful kind of success for us, and for rural education, and for the region."

APPENDIX

Health Education Scope and Sequence, Grades K-6

Topic	K	1	2	3	4	5	6
AIDS						Transmission Risky behaviors	
Drugs	Poison	Medications	Choices Getting along with others	Choices Self-control Tobacco Alcohol	Refusal skills Chew/alcohol	Symptoms Family Dynamics	
Anatomy and physiology		Senses			Body systems	Body systems Cell biology	Growth and development Heredity
Disease	Communicable Prevention			Germs	Communicable Causes		Responsibility for treatment
Mental health	Name feelings	Understand feelings			Self-image Indiv. differ.	Attitudes Decision mak. Problem solv.	Self-esteem
Nutrition	Healthy snacks	Healthy foods	Four food groups	Healthy foods Four food groups	Four food groups Food handling	Meal planning and healthy diet	
Dental	Brushing Fluoride	Losing teeth	Flossing Products Problems	Brushing Flossing Fluoride			
Hygiene	Hand washing Germs			Personal care Showering	Sleep Grooming Products		
Fitness		Activity related to health	Heart health Stretching Coordination	Personal fitness Agility Aerobic activity	Personal fitness Planning		
Child abuse			Talk about touching			Personal rights to privacy	
Relationships						Friendships	
Sexuality					Menstruation (girls only)	Puberty Reproduction (girls/boys segregated classes)	
First aid	Red Cross safety			Red Cross safety			Red Cross babysitting
Safety	Fire Buster Week Name dangers Accident prevention	Buckle up Fire safety	Bicycle Pedestrian	Electrical	Safety rules	Drop and roll Escape routes Smoke detectors	
Health careers		Community workers					
Environmental				Solid waste Recycling	Ecology Pollution		

Comments:

Health Resources Scope and Sequence

Health Education Program Assessment Tool

Date: _____
District: _____
Teacher: _____
Grade Level: _____
(one form for each grade taught)

Planned Topical Units of Instruction	How Well Is This Topic Covered	How Well Prepared to Teach Unit	How Important for Your Grade Level	Major Emphasis of Instruction	Approximate Time Allocation	Integrated into Another Subject Area	Best Resources Used—People and/or Materials	Resources Needed
Content Areas and/or State Standards	N I E R	V S N	V S N	K A SD	No. of Hrs./Year	Identify Subject	Briefly Identify	

Key:
N = not at all
I = introduced
E = emphasis
R = reinforced

V = very
S = somewhat
N = not at all

K = knowledge
A = attitudes
SD = skill development

Adapted from *Health Instruction, A Task Approach*, Burgess Publishing Company

CURRICULUM CATEGORIES

A. AGENCY RESOURCES

Free/relatively inexpensive

Field tested

*Examples: American Cancer Society
American Heart Association
American Red Cross
National Dairy Council

B. BASIC HEALTH SKILL DEVELOPMENT

Skills necessary for implementing positive health behavior
i.e., resistance skills, communications, social skills

*Examples: ASSIST Program (affective skills)
Positive Action
Telesis II: That's Life

C. COMPREHENSIVE

Comprehensive Health Curriculum
covers numerous health content areas

*Examples: Great Body Shop
Merrill/Scott Foresman
Science for Life and Living (BSCS) Kendall-Hunt
Michigan Model

D. CURRICULUM BY SPECIFIC CONTENT AREA

Body/Anatomy and Physiology
Disease
Drugs
Fitness
Human Sexuality
Safety

*Examples: FLASH
McGruff Elementary School Puppet Program
Committee for Children Talking About Touching
STD/HIV AIDS
Physical Best

*These are just a few examples of the many curriculum sources and vendors available on the market for this category.

THOSE WHO HELPED

This book represents the work of scores of school administrators, teachers, parents, community members, health education specialists, and others who helped develop meaningful health education for school children in five Pacific Northwest states.

It is the culmination of the three-year Rural Comprehensive Health Education Project coordinated by the Northwest Regional Educational Laboratory. NWREL worked with six rural school districts from its region, which includes the states of Oregon, Washington, Idaho, Montana, and Alaska, in the development of comprehensive rural health education. Steve Nelson, director of NWREL's Rural Education Program, directed the RCHEP, and Helen Sjolander, a rural specialist with NWREL, served as project manager.

The RCHEP would not have been possible without the generous financial support of the U.S. Department of Education. Thanks also must be extended to each of the school districts, their administrators, community members, and boards of directors who supported this project on the local level.

But it was really the teachers and principals in each of the buildings who made this project work. Without their dedication and perseverance, the Rural Comprehensive Health Education Project would not have thrived. It is not possible to list all of them, but to each we extend our appreciation.

Each school also assigned a contact person, a volunteer if you will, who served as site coordinator. Thanks to Rita Abel and Barb DePaso, Alaska Gateway School District; Craig Kunz, Teton County Schools #401; Dan White, Seeley Lake Elementary District #34; Teresa Clinton and Eleanor Bessonette, Carlton Elementary School District #11; Frank Cardiff, Umpqua School District #45; and Bonnie Seto, Granger School District #204.

Health education specialists played critical roles as resources, consultants, cheerleaders, and collaborators in the three-year effort to build health curriculum. The specialists on this project were Lorraine Davis, vice provost for academic personnel, University of Oregon, Eugene; Jim Girvan, chair, department of health and physical education, Idaho State University, Pocatello; Jane M. Gutting, director of interagency programs, ESD #105, Yakima, Washington; Leslie McBride, associate professor, health studies, Portland State University; Kathleen Miller, associate dean, school of education, University of Montana, Missoula; and Nancy Murphy, assistant professor, department of education, University of Alaska/Fairbanks.

The contents for this book were generated during the three-year life of the RCHEP. The framework evolved as participants got to know each other during a series of meetings at the NWREL offices in Portland, Oregon. The conversations, observations, and stories that the participants shared during those meetings were invaluable in setting the tone, establishing the direction, and providing the foundation. Good rural folks all, they included:

Oregon: Eleanor Bessonette, principal, Teresa Clinton and Rich Moberg, teachers, and Suzanne Farmer, child development specialist, Carlton Elementary School; Frank Cardiff and Cindy Goff, teachers, Umpqua School District; and Leslie McBride, associate professor, health studies, Portland State University.

Idaho: Jim Girvan, chair, department of health and physical education, Idaho State University; Wilda Ball, teacher, health education, and Craig Kunz, principal, Teton Middle School; and Jannifer Cooke, teacher, Victor Elementary School.

Washington: Jane Gutting, director of interagency programs, ESD #105, Yakima; Bonnie Seto, school nurse, Judy Hurlburt, teacher, and Tony Whitley, health teacher, Granger School District.

Montana: Kathleen Miller, associate dean, school of education, University of Montana; Dan White, principal, Kathleen Thompson, primary teacher, and Becky Gehrke, physical education/health educator, Seeley Lake Elementary School.

Alaska: Nancy Murphy, assistant professor, department of education, University of Alaska/Fairbanks; and Rita Abel, elementary/high school teacher, and Barb DePaso, sixth-grade teacher, Tok School.

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Tony Kneidek of the Northwest Regional Educational Laboratory was the primary writer, photographer, and editor for this book.

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ADDITIONAL READING

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TECHNICAL SUMMARY

In 1989, Northwest Regional Educational Laboratory (NWREL) convened a rural curriculum study committee to identify the barriers and enabling factors that affect curriculum renewal in small, rural schools.

The committee included representatives from state education agencies responsible for ensuring that basic education standards in the state are achieved, as well as representatives from other rural school improvement organizations. The committee identified key factors which either impede or facilitate local curriculum renewal in the small, rural schools of the region. Three bipolar contextual factors emerged:

Leadership: Strong, committed leadership which is open to organizational input could facilitate curriculum renewal. The absence of board, administrator, community, and/or staff leadership could limit efforts for renewal.

Resources: The small organizational size of rural schools can promote flexibility and ease some of the obstacles associated with change. There is less bureaucracy and red tape, and more personal communication to foster change and the sharing of information. Limited fiscal resources, staff time, expertise, and access to information can constrain curriculum renewal opportunities.

Incentives: A regulatory environment which provides fiscal and/or policy incentives for renewal, coupled with outside technical assistance and integrated approaches to curriculum, promotes local renewal. A compliance orientation with few resources available for educational improvement, recognition, or rewards detracts from local renewal opportunities.

The purpose of the Rural Comprehensive Health Education Project (RCHEP) was to demonstrate that quality comprehensive school health education can be implemented successfully in small, rural schools by influencing these three contextual factors.

With the support of a U.S. Department of Education grant, NWREL coordinated a three-year Fund for the Improvement and Reform of Schools and Teaching project in six demonstration sites to expand the regional capacity to plan, develop, and install a comprehensive school health education program. District enrollments ranged from 72 students in the smallest district to 1,050 in the largest.

Goals of this project were threefold:

1. Establish a regional network of health education curriculum specialists located in state education agencies, institutions of higher education, and other educational service agencies
2. Establish and demonstrate a site-based planning model for implementing school health education in small, rural, distressed settings
3. Expand practitioners' awareness of the range of comprehensive school health education curriculum activities and options

During the 1989–90 school year, six small, rural school districts serving disadvantaged students were selected from across the five-state region served by NWREL to participate in the three-year project. Each site was provided financial support, access to curriculum models, and a field-based health education specialist from a university or educational service agency. Specialists facilitated planning and implementation of a comprehensive school health education program guided by the district's local school health education planning team. Participants completed a district health-instruction needs assessment and attended a regional health education curriculum fair, where they selected materials which reflected identified needs.

Throughout the second year, participants implemented curriculum, provided staff inservice activities, and evaluated progress. Curriculum implementation was supported by local staff development efforts that reflected both local needs and compliance with state standards and guidelines.

During the final year, districts continued to implement the curriculum. In addition, they assisted other small, rural schools and agencies in addressing comprehensive school health education needs and issues.

By the conclusion of the grant period, the project resulted in the short- and long-term benefits associated with:

1. Demonstration of a small, rural local education agency planning process for assessing local health education needs, curriculum options, and instructional improvement
2. Increased visibility and access to demonstration models of comprehensive school health education programs in each Northwest state which are effective in rural, small school settings

3. Demonstration of the use of consultant-based staff development and technical assistance strategies for the effective implementation of comprehensive health education curricula

4. Expanded capacity for dissemination, implementation, networking, and team building for comprehensive school health education across the Northwest region

The project fostered comprehensive health education development at the six sites, and, equally important, provided a framework for change that is proactive and inclusive. The RCHEP provided the following:

- Incentives for school administration, board, staff, and community to engage in health curriculum renewal.
- Fiscal support that allowed for release time, expert consultants, and curriculum development — three vital elements for successful health education renewal.
- A framework for effective leadership, which was encouraged through the use of the health specialists and local team-building activities. Each district school board was required to adopt a resolution of support to ensure their commitment to the effort.

The evidence suggests that NWREL's original assumptions were well-founded. The six rural school pilot sites demonstrated remarkable progress and commitment toward comprehensive school health education. Similarly, these schools provide the following valuable lessons to other rural educators and the organizations which serve them:

1. There is no single, all-purpose curriculum that addresses the comprehensive school health education needs of small, rural schools. Moreover, the *process* of achieving a comprehensive school health education curriculum is vitally important.

These is no absolute point where a school can affirm that a comprehensive health education program has been achieved. Like reading, writing, and mathematics, there is never enough time or resources to teach all that can be taught. Districts and schools set priorities and make decisions. But teacher creativity carries the most important messages on to the classroom.

In small, rural schools, comprehensive health curriculum can be integrated and students can be provided the opportunity to apply the most important health skills—communication, decision-making, and personal responsibility for their own health and the health of their communities.

2. Rural school personnel take a holistic view. A focus on health education evolves into school health promotion with a wellness orientation. Similarly, because of the close ties between the rural school and community, school health quickly evolves into a community health effort. Family involvement in implementing health promotion activities will occur.

3. Small, rural schools are unique and special. They deserve recognition and are proud of their accomplishments. They are naturally skeptical of urban models and urban experts. Their self-reliance and pride is an asset. Their message is clear: "Show us the alternatives, provide us with resources and information, and we will build an effective program that is valued in our community."

4. Dissemination and demonstration efforts take a grass-roots perspective. The target audience for dissemination is local peers — teachers, administrators, and board members who share similar daily challenges as educators. Participants said local and regional demonstration activities, particularly those onsite, were most effective and desirable. Similarly, participants felt that demonstration of the planning process was more effective and meaningful than detailing the particular curriculum they adopted.

FOR MORE INFORMATION

REGIONAL

Northwest Regional Educational Laboratory	503/275-9488

STATE

Alaska	
Alaska State Department of Education - Health	907/465-2841
Alaska Gateway School District - Tok School	907/883-5161
University of Alaska Fairbanks - Education	907/474-6589
	907/474-5115
Alaska Health Education Consortium	907/343-4622
Idaho	
State Department of Education - Health and PE	208/344-2281
Idaho State University - Department of Health, PE, and Dance	208/236-2656
Teton County School District - Teton Middle School	208/354-2971
Victor Elementary School	208/787-2245
Montana	
Office of Public Instruction - Department of Health Enhancement	406/444-4434
The University of Montana - Health and Human Performance	406/243-4211
Montana State University - Health and Human Development	406/994-4001
Eastern Montana College - Human Performance & Health Studies	406/657-2370
Western Montana College - Rural Education	406/683-7121
MAHPERD - call OPI for current information	
Seeley Lake Elementary	406/677-2265
Oregon	
Oregon Department of Education - Health & PE	503/378-3602
Umpqua Elementary School SD #45	503/459-3438
Carlton Elementary School	503/852-7161
Portland State University - Health Studies	503/725-5102
Washington	
Office of State Superintendent of Public Instruction - Health & PE	206/753-6752
Eastern Washington University - Center for Rural Teacher Education	509/458-6200
Western Washington University, Dept. of Health, PE & Recreation	206/676-3106
ESD #105 - Rural Health Ed Center for Quality Schools	509/575-2885
Puget Sound ESD - Health Education Center	206/439-6921
Granger School District -Roosevelt Elementary	509/854-1420
Granger High School	509/854-1115
CHEF-Comprehensive Health Education Foundation	206/824-2907
	800/323-CHEF

For information on health associations, state chapters of AAHPERD, and upcoming conferences, call your respective state departments. Many of the national organizations have state chapters.

For Wellness Conferences information, call state departments for current information (in Alaska, Seward Wellness; in Oregon, Seaside Health Conference; in Montana, Rocky Mt. Rendezvous; in Idaho, Great Potato Conference; in Washington, Fort Worden Wellness Conference).

NATIONAL GOVERNMENT AGENCIES

Department of Education

Fund for the Improvement and Reform of
Schools and Teaching
Comprehensive School Health Education Program
555 New Jersey Avenue, NW, Room 522
Washington, DC 20208-5524
202/219-1496

Department of Health and Human Services

Adolescent Pregnancy Program
Room 736E, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
202/245-7473

Division of Adolescent & School Health
Center for Prevention of Chronic Diseases
Centers for Disease Control
Building 3, Room 108, Mailstop 11
1600 Clifton Road, NE
Atlanta, GA 30333
404/639-3037

Maternal and Child Health Coordinator
Indian Health Service
Parklawn Building, Room 6-22
5600 Fishers Lane
Rockville, MD 20857
301/443-1948

Office of Minority Health
Hubert H. Humphrey Building, Room 118F
200 Independence Avenue, SW
Washington, DC 20201
202/245-0020

Children and Schools Program
Office of Disease Prevention and Health Promotion
Switzer Building, Room 2132
330 C Street, SW
Washington, DC 20201
202/472-5660

Environmental Protection Agency

Environmental Health Education Task Force
26 Federal Plaza, Room 737
New York, NY 10278
212/264-7364

National Organizations

American Academy of Pediatrics
1331 Pennsylvania Avenue, NW, Suite 721
Washington, DC 20004
202/336-5475

American Alliance for Health, Physical Education,
Recreation and Dance
1900 Association Drive
Reston, VA 22091
703/476-3404

American Association of School Administrators
1800 North Moore Street
Arlington, VA 22209
703/528-0700

American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329
404/329-7719

American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855
301/762-6102

American Council of Life Insurance/
Health InsuranceAssociation of America
Education Relations and Resources
1001 Pennsylvania Avenue, NW
Washington, DC 20004
202/624-2424

American Health Foundation
320 East 43 Street
New York, NY 10017
212/953-1900

American Heart Association
1250 Connecticut Avenue, NW, Suite 360
Washington, DC 20036
202/822-9380

American Lung Association
1740 Broadway
New York, NY 10019
212/315-8728 and 8730

American Medical Association
535 North Dearborn Street, #5251
Chicago, IL 60610
312/645-4472 and 5315

American Nurses Association
16 Linda Place
Fairfield, NJ 07006

American Public Health Association
1015 15th Street, NW
Washington, DC 20005
202/789-5600

American Red Cross
1730 E Street, NW
Washington, DC 20006
202/639-3039

American School Health Association
National Office
P.O. Box 708
Kent, OH 44240
216/678-1601

Association for the Advancement of
Health Education
1900 Association Drive
Reston, VA 22091
703/476-3437

Children's Defense Fund
122 C Street, NW
Washington, DC 20005
202/628-8787

Comprehensive Health Education Foundation
22323 Pacific Highway South
Seattle, WA 98198
206/824-2907

Education, Training and Research Associates
P.O. Box 1830
Santa Cruz, CA 95061
408/438-4060

Department of Health and Safety
Metopolitan Life Insurance
One Madison Avenue
New York, NY 10010
212/578-5009

National Association of School Nurses
Lamplighter Lane
Scarborough, ME 04074
207/883-2117 and 2683

National Association of Teachers of
Comprehensive Health
c/o Richard Loya
Highland Park High School
6020 Miles Avenue
Huntington Park, CA 90255
800/962-8243

National Center for Health Education
30 East 29th Street
New York, NY 10016
212/689-1886

National Education Association
1590 Adamson Parkway, Suite 260
Merrow, GA 30260
404/875-8819

National Mental Health Association
420 East 4th Street
Hinsdale, IL 60521
708/986-1800

National Rural and Small Schools Consortium
Miller Hall 359
Western Washington University
Bellingham, WA 98225
206/676-3576

National School Boards Association
1680 Duke Street
Alexandria, VA 22314
703/838-6722

Besides information, a variety of reasonably priced resource materials come from agencies and organizations. Check in your state for affiliations of these organizations.

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